

10-2237

**IN THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT**

CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC.,
Plaintiff-Appellant,

v.

M. JODI RELL, Governor, State of Connecticut, MICHAEL P. STARKOWSKI,
Commissioner of Social Services,
Defendants-Appellees.

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

**BRIEF OF *AMICUS CURIAE* CONNECTICUT ASSOCIATION OF NOT-
FOR-PROFIT PROVIDERS FOR THE AGING IN SUPPORT OF
PLAINTIFF-APPELLANT, SEEKING REVERSAL OF DISTRICT
COURT'S DENIAL OF A PRELIMINARY INJUNCTION**

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1, the corporate *amicus curiae*, Connecticut Association of Not-For-Profit Providers for the Aging (CANPFA), hereby discloses that it is a private, not-for-profit, 501(c)(6) trade association representing Connecticut's non-profit long-term care providers. CANPFA further discloses that it has no parent company and no publicly held corporation owns 10% or more of CANPFA's stock.

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STATEMENT OF INTERESTS OF *AMICUS CURIAE*

The Connecticut Association of Not-for-Profit Providers for the Aging (“CANPFA”) submits this brief as *amicus curiae* in support of the plaintiff-appellant Connecticut Association of Health Care Facilities, Inc. (“CAHCF”). CAHCF is seeking reversal of the district court’s denial of a preliminary injunction barring enforcement of a Connecticut statute that freezes Medicaid payment rates to nursing homes.¹

CANPFA is a non-profit, tax-exempt 501(c)(6) corporation that was founded in 1961 to represent and promote the interests of Connecticut’s not-for-profit long-term care providers. CANPFA’s purpose is to protect and advance the interests of not-for-profit long-term care providers in this State. It is “dedicated to advancing the quality of services and care for older adults and chronically ill individuals by leading, educating, representing, advocating and servicing its members who are both mission-driven and not-for-profit providers representing the continuum.” CANPFA Mission Statement, adopted in 2003 and reaffirmed on December 15, 2005.

¹ No party’s counsel authored this amicus brief in whole or in part, and no party or party’s counsel contributed money to fund the preparation or submission of this brief, and no other person (other than the *amicus curiae*), contributed money to fund the preparation or submission of this brief. 2d Cir. Local Rule 29.1.

CANPFA currently has 136 member organizations serving thousands of older adults and chronically ill individuals on a daily basis at their facilities and in the community. CANPFA's members provide services along the full continuum of long-term care. CANPFA's membership includes forty-eight not-for-profit nursing homes – “nursing facilities” within the meaning of 42 U.S.C. 1396r(a) – as well as chronic disease hospitals, residential care homes, subsidized senior housing, continuing care retirement communities, assisted living facilities, home health care agencies, and adult day care centers.

All parties to this appeal have consented to the filing of this brief.

ARGUMENT

I. Introduction²

Like the nursing homes that are represented in this litigation by CAHCF, CANPFA's nursing home members care for the elderly and the chronically ill. They receive Medicaid reimbursement through the same statutory and regulatory processes as the CAHCF nursing homes,³ and they face the same dire financial circumstances as a result of the State's decision to set Medicaid reimbursement based not on the federally required analysis of the costs of providing care to the elderly and chronically ill, but on the state budget.

CANPFA understands the fiscal crisis facing the State today, and has long worked with the State towards meaningful reform in the manner and cost of delivery of essential services to the elderly and chronically ill. CANPFA intends to continue that working relationship, including participation in efforts to rebalance the continuum of care to expand the use of community-based care options. But Section 32 of Connecticut Pub. Act 09-5, which freezes (and effectively reduces)

² CANPFA adopts the legal analysis in CAHCF's opening brief in this appeal, filed on August 2, 2010 ("CAHCF Brief"), and this *amicus* brief therefore does not repeat that analysis. This brief uses "JA" to refer to the parties' Joint Appendix in this appeal, "SPA" to refer to the Special Appendix filed by CAHCF in this appeal, and "CA" to refer to the CANPFA Appendix to this *amicus* brief, for which leave of court is separately sought..

³ Forty-five of CANPFA's forty-eight nursing homes participate in the Medicaid program.

Medicaid reimbursement for nursing homes for the next two years,⁴ is fundamentally inconsistent with federal law, as demonstrated in the CAHCF Brief. It threatens the continued viability of nursing homes – the cornerstone of care for the elderly and chronically ill in our State.

In denying CAHCF's motion for a preliminary injunction, the district court gave short shrift to the devastating impact of Section 32's Medicaid rate freeze on nursing facilities in Connecticut, which are the core of the continuum of long-term care for the elderly and infirm. The court held that Section 30(A) of the federal Medicaid statute (42 U.S.C. § 1396a(a)(30)(A) (CAHCF Special Appendix ("SPA") p. 19)⁵ imposes no procedural requirements on the State and that the State is therefore free to set Medicaid payments based solely on the State's budget concerns, *CAHCF v. Rell*, No. 3:10-cv-136, 2010 WL 2232693, at *8-9 (D. Conn.

⁴ As discussed in CAHCF's opening brief in this appeal ("CAHCF Br."), current nursing home Medicaid rates are based on nursing home Medicaid allowable costs for 2003, trended forward for inflation (and subject to internal caps and yearly stop gain). CAHCF Br. at 9-11. Conn. Gen. Stat. § 17b-340(f)(8) would have required that DSS rebase costs beginning with the 2010 rate year, but Section 32 froze Medicaid rates through 2011 based solely on state budget considerations and therefore rebasing did not occur. As discussed in the CAHCF Brief, the Governor's February 2009 budget proposal noted that rebasing would result in a rate increase of **9.64%** in FY 2010, and so Section 32 was the functional equivalent of a 10% cut. CAHCF Br. at 17.

⁵ Section 30(A) requires States to have methods and procedures necessary to assure that Medicaid payments "are consistent with efficiency, economy and quality of care" and sufficient to attract enough providers to assure equal access to care for Medicaid recipients.

June 3, 2010)(“CAHCF I”). That ruling contradicts decisions in other federal and state courts that have addressed the issue. *See* CAHCF Br. at 43-52.

As to § 30(A)’s substantive quality of care and equal access standard, the district court allowed CAHCF’s claim to go forward, but denied a preliminary injunction -- applying a “deferential standard” in light of the State’s economic circumstances. CAHCF I, at 10. The court expressed skepticism about the impact of § 32 on nursing homes and their ability to survive and provide equal access to quality care, despite the overwhelming evidence of their desperate financial condition submitted by CAHCF. The court also erroneously speculated that nursing homes’ financial problems might be due to the rise in alternative, community-based care programs, *id.* at * 11-12.

CANPFA submits this *amicus* brief to underscore a) the severity of the financial crisis facing nursing homes in Connecticut, including CANPFA member facilities, as a result of the ongoing Medicaid rate freeze imposed by § 32 (Part II *infra*), b) the dependence CANPFA members and other nursing homes on Medicaid funding and the extraordinary difficulties they face in reducing or shifting costs or in leaving the Medicaid program (Part III *infra*), and c) the threat posed by § 32 to the crucial role that nursing homes continue to play in the continuum of long-term care, even with the advent of alternative, community-based care programs (Part IV *infra*).

II. Not-for-Profit Nursing Homes Receive Medicaid Reimbursement Substantially Below Their Costs and Cannot Recover Those Losses

The record below and CAHCF's Brief amply demonstrate that nursing homes in the State have long received Medicaid reimbursement well below the cost of the services they provide. CAHCF Br. 9-11, 12-15. CAHCF's expert, Joseph Lubarsky, found that 89% of 232 Connecticut nursing facilities reviewed continue to be paid less than the allowable cost of providing services to Medicaid patients during the current fiscal year (July 1, 2009 through June 30, 2010). Declaration of Joseph M. Lubarsky ¶ 29 (JA 550). Even the 81% of those facilities operating with the lowest cost and greatest efficiency are experiencing shortfalls. *Id.* ¶ 33 (JA 551-52). Mr. Lubarsky concluded that the vast majority of nursing homes lose \$20.92 every day for each Medicaid resident, based on a Medicaid day-weighted average. For a 116-bed facility with 95% occupancy and two-thirds of the census being Medicaid residents, a \$20.92 per resident per day shortfall adds up to an annual loss of \$563,800 related to Medicaid services. *Id.* ¶ 32 (JA 551).⁶

The rate reductions under Section 32 make the nursing homes' situation untenable. Even the district court acknowledged that "the gap between costs and reimbursement rates will negatively influence the institutions' financial situations," a claim the court said "cannot be denied." *CAHCF I*, at * 11. As CANPFA's

⁶ Mr. Lubarsky's analysis compared the 2010 Medicaid rates to the projected 2010 Medicaid allowable per diem costs for 232 licensed nursing homes in the State.

former board chair, David Bordonaro, testified in February 2009, in opposition to the rate freeze that ultimately became section 32: “While this may appear to be a stabilization of funding, the fact is that no rate increase for three straight years will have a devastating effect on the level of services that we will be able to provide. We have seen what happens when the Medicaid rates fall so far behind that the strain becomes too much – providers teeter on bankruptcy, quality providers leave the field, and others are reluctant to enter the field. This is already happening and will be accelerated if the Governor’s proposal is adopted.” JA-118.

Nursing homes are incurring substantial losses as a result of the State’s refusal to follow the provisions of federal law requiring rate-making procedures to assure that payments are “consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers” to ensure access to services.

§ (30)(A) (SPA 19). As discussed in CAHCF’s brief (pp. 66-67), nursing homes have no remedy in federal court to recover those losses, because the Eleventh Amendment bars such a recovery. In the absence of a preliminary injunction, nursing homes will continue to mount losses averaging \$20.92 a day on every Medicaid resident – month after month until the litigation concludes, with the federal courts powerless to provide a remedy for those losses. The nursing homes’ losses therefore constitute irreparable harm for purposes of determining whether a preliminary injunction is warranted. *Id.* Moreover, as discussed in the sections

that follow, the nursing homes have little or no ability to leave the Medicaid program, reduce their reliance on Medicaid funding, or shift their unreimbursed Medicaid costs to non-Medicaid patients.

In short, CANPFA's nursing home members are trapped in a system that underfunds the Medicaid services they provide and saddled with losses they cannot recover. That cannot be what the Congress had in mind when it passed 42 U.S.C. § 1396(a)(30)(A), which requires the State to establish Medicaid rates that "bear a reasonable relationship to efficient and economical [providers'] costs of providing quality services," absent some sound justification for deviating from that principle. *See Independent Living Center of S. Cal. Inc. v. Maxwell-Jolly*, 572 F.3d 644, 651 (9th Cir. 2009); *see also California Pharmacists Ass'n v. Maxwell-Jolly*, 596 F.3d 1098 (9th Cir. 2010).

III. Not-for-Profit Nursing Homes Are Dependent Upon Medicaid Funding, and Have Few Options to Increase Other Revenues, Reduce Costs, Or Shift Costs to Deal with the Rate Reductions Imposed by Section 32

In reality, almost all of the State's nursing homes, including 45 of the 48 nursing homes that are members of CANPFA, participate in the Medicaid program. According to the State's September 2008 nursing home census report, on average, 69% of the nursing home population is comprised of Medicaid residents. *See* Office of Policy and Management, Annual Nursing Facility Census, September 30,

2008. JA 245-46.⁷ The individual nursing home residents on Medicaid have little choice and few meaningful alternatives. CANPFA's President testified in 2009 that

“Medicaid dependent residents are individuals who have led long and productive lives, who have accessed care from other elements of the long term care continuum, who have moved along that continuum as they have aged or as their disease has progressed . . . Contrary to popular belief, *Medicare* does not pay for long term nursing home care. Therefore an elderly resident must pay for their nursing home care privately until their private resources are exhausted (or “spent down”), and then their only option is to apply for and receive state assistance – which is Medicaid.”

Testimony of Mag Morelli, CANPFA President, May 18, 2009 (JA-204).⁸

The fate of Connecticut's nursing homes, and the frail elderly residents who depend upon them, is inextricably tied to Medicaid funding, and, as discussed below, those facilities have few options to alter their situation.

⁷ A recent decision by the state Department of Social Services confirmed that 229 out of 241 nursing facilities in the state participate in Medicaid. *In the Matter of: Courtland Gardens Health Center, Inc.*, Docket No. 10-710, p. 3 (July 1, 2010), <http://www.ct.gov/dss/cwp/view.asp?Q=462966&A=2345> (“Courtland Gardens”) (CA90). Cites to “CA” are to CANPFA's appendix, which is attached hereto at CA1-CA98.

⁸ The economic crisis of the last two years has only exacerbated the problem. More incoming nursing home residents qualify for Medicaid, and those who do not qualify when they enter a facility tend to come in with fewer assets and therefore exhaust those assets and become Medicaid eligible more quickly than in prior years.

A. As A Practical Matter, Nursing Homes Cannot Leave the Medicaid Program.

For almost all nursing homes, leaving the Medicaid program is not a realistic option, and there are significant penalties for withdrawing from the Medicaid program. The State has attempted to downplay the those penalties and the difficulty of leaving the Medicaid program, without mentioning the web of strings attached to such a departure. Connecticut law provides that a nursing home seeking to terminate its Medicaid provider agreement “shall be responsible for any loss of federal financial participation arising from such termination,” Conn. Gen. Stat. § 17b-347(a), i.e., it must pay for the loss of federal matching funds to the State for its Medicaid residents – an enormous burden.⁹ Once the facility withdraws from the Medicaid program, its self-pay rates, unlike the self-pay rates of Medicaid-participating facilities, become subject to DSS regulation. Conn. Gen. Stat. § 17b-341(a)(2). As a practical matter, therefore, most nursing homes cannot leave the Medicaid program.

Even shutting down a nursing home is a restricted option. DSS has authority to deny a nursing home’s application for the “Certificate of Need” that is required

⁹ Since Medicaid is a joint federal/state program, the federal government matches state Medicaid expenditures. In Connecticut, the State receives fifty cents for every dollar of Medicaid money spent; with the federal stimulus legislation, this percentage increased to 60% for the current year. Under Conn. Gen. Stat. § 17b-347(a), a facility wishing to leave the Medicaid program would need to pay for the State’s loss of federal matching funds.

under state law to close a Medicaid certified nursing facility. Conn. Gen. Stat. §§ 17b-352 – 17b-355. DSS recently denied such an application, despite the applicant’s financial losses in excess of \$3.9 million in 2009. *Courtland Gardens*, p. 2 (CA89)(*see n.7 supra*).¹⁰

B. Nursing Homes Have Few Options for Reducing Losses from Medicaid Residents and Non-Paying Residents

Nursing homes cannot reduce the number of Medicaid residents they accept, because state law prohibits them from discriminating in admissions based on how a prospective resident will pay for his or her care. Conn. Gen. Stat. § 19a-533. With few exceptions,¹¹ nursing homes must admit all residents, which effectively means all Medicaid residents, to the next available bed.

Facilities are also effectively unable to avoid losses from non-paying private pay residents, because it is very difficult to discharge residents. Except in specific, statutorily defined circumstances, Conn. Gen. Stat. § 19a-535 prohibits involuntary

¹⁰ DSS based its decision in part on its determination that closure of the facility would have resulted in an unacceptably high 97% occupancy rate in the remaining nursing homes in the area. *Courtland Gardens*, pp. 6, 10 (CA93, 97). That determination provides a reality check on the district court’s view that nursing home losses and closures may be attributable to reduced demand for nursing homes, i.e., an excess of nursing home beds. *See CAHCF I*, at *12.

¹¹ A nursing home may skip over an indigent person on its waiting list if its self-pay census is equal to or less than 30% or if the vacancy is in a private room. Conn. Gen. Stat. § 19a-533(f) and (g). However, a nursing home in the unfortunate situation of having less than 30% private pay residents is hamstrung in its ability to shift costs to private pay residents in any event.

discharges.¹² If a facility seeks to discharge a self-pay resident for nonpayment, the resident has a right to an administrative appeal to DSS. Conn. Gen. Stat. § 19a-535(c),(h). DSS typically does not allow the discharge if the resident has applied for Medicaid – even if Medicaid eligibility has not yet been granted. And even if the resident has not applied for Medicaid and the facility establishes that the resident has failed to pay, DSS may sustain the resident’s appeal if the facility is unable to provide a discharge plan for the resident to go to a specific alternative facility or to be cared for at home. As a practical matter, facilities cannot discharge residents who have no source of payment because other facilities will not accept them. This means that residents generally remain, and the facility bears all of the costs of their care unless and until they become eligible for Medicaid.

As a result, it is virtually impossible for nursing homes to avoid or limit Medicaid admissions, or to change their payor mix to improve revenue streams as a means of offsetting the cuts in Medicaid reimbursement imposed by Section 32.

¹² A facility may not transfer or discharge a resident, “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 in the case of a self-pay patient, for his nonpayment or arrearage of more than fifteen days of the per diem facility room rate, or the facility ceases to operate.” Conn. Gen. Stat. § 19a-535(b).

C. Nursing Homes Lack Effective Options for Reducing the Costs of Care or Shifting Costs Onto Non-Medicaid Residents.

Nor are there effective options for reducing the facilities' costs in response to the Medicaid funding cuts that the legislature enacted. The costs of CANPFA's not-for-profit nursing homes are overwhelmingly for personnel and other expenses directly related to the care of residents. "[T]here are not many places we can go to find these cuts. 70% of our costs are related to personnel. Staffing, heat, medical supplies, food – these are our expenses." Feb. 18, 2009 Appropriations Committee Testimony of D. Bordonaro, CANPFA Chair (JA-118).

Given tight federal and state regulation of nursing homes,¹³ cutting back on staffing, quality and level of service is not a realistic option. As the University of Connecticut Health Center noted in its June 2007 *Connecticut Long-Term Care Needs Assessment*, Part 1: p. 22: "Quality of care in nursing homes has been the focus of considerable attention among policymakers, consumers, advocates and providers for decades . . . Accordingly, the nursing home industry is heavily regulated at the federal and state levels. State survey agencies are required to inspect nursing facilities every 9 to 15 months in categories that include resident rights, quality of care and life, resident assessment, services, dietary, pharmacy, rehabilitation, dental and physician, physical setting, and administration." *Id.*

¹³ See Connecticut Public Health Code, Conn. Agency Regs. § 19-13-D8t (nursing home licensure requirements) and 42 C.F.R. § 483.1 et. seq. (long term care facility Medicare and Medicaid requirements).

(CA87). Nursing homes that violate these uncompromisingly high standards risk fines, denial of Medicare and Medicaid payments for new admissions, appointment of a temporary outside manager, and other sanctions up to and including, in the most serious circumstances, loss of license and termination from the Medicare and Medicaid programs. *See* Conn. Gen. Stat. §§ 19a-494, 19a-524 to 19a-529; 42 U.S.C. §§ 1395i-3(h) and 1396r(h); 42 C.F.R. § 488.400 et. seq.

Shifting unreimbursed costs onto non-Medicaid patients is also not a realistic option for CANPFA's nursing homes. A 2001 legislative report by the Office of Legislative Research and a University of Connecticut Health Center report, both citing a study by BDO Seidman, LLP, recognized that shifting Medicaid costs onto Medicare and private payers is extraordinarily difficult, due to changes in the mix of nursing home populations and reductions in Medicare payments. *See* OLR Research Report, "Studies on Adequacy of Medicaid Reimbursements to Nursing Homes," Nov. 8, 2001 (JA-400); June 2007 *Connecticut Long-Term Care Needs Assessment*, JA-388; *see also* LPRI Report, "Medicaid Rate Setting for Nursing Homes," Dec. 2001 (JA-295)(it "is becoming increasingly difficult" for nursing homes to shift unreimbursed Medicaid costs to other payers because "nursing home populations are primarily Medicaid (70 percent) and that ratio continues to grow," Medicare has reduced payments, and private pay patients have alternative care options other than nursing homes).

D. The Growing Medicaid Population and Increasing Acuity of Nursing Home Residents Exacerbates the Financial Crisis That Nursing Homes Face

The Connecticut Long-Term Care Planning Committee's January 2010 report to the General Assembly on its Long-Term Care Plan reported that the Medicaid population in nursing homes continues to increase.¹⁴ While the percentage of Medicare residents also increased from 10.7% in 1995 to 15.7% in 2008, the percentage of private pay residents declined dramatically from 20.2% to 12.0% during the same period, and those covered by insurance declined to a negligible 1.4%. *See Connecticut Long-Term Care Plan, A Report to the General Assembly, January 2010, p. 34,* <http://www.cga.ct.gov/coa/PDFs/Reports/LTC%20Plan%20-%202010%20PDF.pdf> (CA38). This trend diminishes nursing homes' ability to survive declining Medicaid rates by relying on other sources of payment. Nor does the State anticipate that private payment for long-term care will increase significantly in the near future. The Long-Term Care Plan sets as one of its "goals" to increase the proportion of long-term care costs covered by private sources to 25% -- **by the year 2025.** *Id.* at 55.

¹⁴ The General Assembly established the Long-Term Care Planning Committee (comprised of a wide range of State officials whose responsibilities encompass long-term care in some way), and charged the Committee with developing a long-term care plan for the State. *See Conn. Gen. Stat. § 17b-337.* The Committee is required to submit a plan to specified committees of the General Assembly. § 17b-337(d).

These structural and financial problems facing nursing homes are exacerbated by the increased acuity of nursing home resident population. A 2008 legislative report noted that, while the total number of nursing home beds in the State has dropped since 1992, “there has been a dramatic shift in the types of beds that remain as many homes have converted their less-skilled, rest home with nursing supervision (RHNS) beds to more costly, higher-skilled chronic and convalescent nursing home (CCNH) beds.” OLR Research Report, “Nursing Homes,” Jan. 16, 2008, JA-389. (That same report acknowledged that “the nursing home industry faces more bankruptcies, receiverships, and closures in part due to the inadequacy of Medicaid reimbursements . . . ” JA-390) As a result, those remaining in long-term care facilities are the weakest residents, requiring the greatest care at the greatest cost.¹⁵ These are overwhelmingly Medicaid residents, for whom the facilities continue to be chronically underpaid and to whom the facilities are required by law to provide the highest standards of care.¹⁶

¹⁵ According to the University of Connecticut Health Center’s June 2007 *Connecticut Long-Term Care Needs Assessment*, (Part 1: p. 21) (CA86), “[o]f all residents living in nursing homes, three-quarters require assistance with at least three activities of daily living, including bathing, dressing, eating, and using the toilet; 12 percent had a psychiatric diagnoses (i.e. schizophrenia) (Pandya, 2001) and half (50%) of residents were diagnosed with dementia (Alzheimer’s Association, 2006).”

¹⁶ Federal and state laws require that facilities meet the needs of all residents, regardless of the complexity or acuity of their conditions. Connecticut’s strict quality of care requirements are discussed above, p. 13-14 & n.13 *supra*.

In its January 20, 2010 report on major issues facing the legislature, the Office of Legislative Research recognized that nursing homes' costs have gone up in part because the acuity level of their residents has increased, compounding the problems caused by Medicaid reimbursement rates that do not reflect the facilities' costs. "The rate setting system is cost-based but does not take into account the acuity of a resident's needs, and the complex rate formula has been rendered moot in recent years as the legislature has either appropriated flat rates or frozen them altogether." JA-397.

Thus, long-term care facilities have few options to leave the Medicaid program, reduce their percentage of Medicaid recipients or the acuity of their needs, or shift unreimbursed costs onto non-Medicaid residents. As a result, faced with ongoing losses from their Medicaid residents, they are trapped in an untenable situation. Not surprisingly, from 2002 through 2009, twenty-two nursing homes in Connecticut, with over 2,000 beds, closed. JA-196, 452. In 2009, before Section 32's enactment, ten nursing homes were in receivership and

Similarly, under federal requirements for participation in Medicare and Medicaid, "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." 42 C.F.R. § 483.25.

six others were in bankruptcy.¹⁷ JA-451. Section 32's Medicaid rate reductions portend even further harm to the industry.

IV. Section 32's Reduction In Medicaid Reimbursement Threatens The Full Continuum Of Elder Care That Not-for-Profit Nursing Homes Anchor

The financial threat to nursing homes from Section 32's ongoing cut in Medicaid rates not only threatens CANPFA's nursing homes and their residents, but risks broader harm to the communities they serve. As "the providers of post-acute patient care, short-term physical and occupational rehabilitation and therapy care, and extremely important respite care," Testimony of Trish Walden, Southington Care Center, May 18, 2009 (JA-206), nursing homes are the cornerstone of a continuum of care provided to the elderly and chronically ill. *See also* Long-Term Care Plan, p. 3 (CA7) ("[i]nstitutional care plays a vital role in the continuum of long-term care.")

Nursing homes remain the most critical component of that continuum of care, even as the State and nursing homes pursue the goal of rebalancing to expand alternative, community-based long-term care options. Those alternatives – cited by the district court, with no support, as a possible cause of the nursing home financial crisis, *CAHCF* at * 12 – are important to pursue, but they do virtually nothing to ease the pressure on nursing homes today.

¹⁷ Ironically, receiverships can be extraordinarily costly, since additional state funds must be expended to support the extensive administrative costs of the receivership.

Rebalancing long-term care options to shift services from institutional care to community-based care options is a central component of the State's Long-Term Care Plan. It is a goal that is embraced by CANPFA's members and the nursing home industry in general. But it is a long-term goal, not a short-term reality. The State's Long-Term Care Plan aspires to a ratio of 75% community-based care to 25% institutional care, by the year 2025. But the current ratio is 53%-47%.¹⁸ Long-Term Care Plan, p. 48 (CA52).

Nursing homes will have to play a crucial role in delivering care to the elderly, long into the future. Even if viable alternatives develop, many will "prefer or need the care provided in a nursing facility or similar institutions." Long-Term Care Plan, p. 69 (CA73). And given the projected growth in our elderly population,¹⁹ "by 2030, the need for [such] institutions will increase by 43 percent." *Id.*

¹⁸ The lack of substantial community-based care options has been a point of concern to advocacy groups for the disabled, because many end up in institutional settings due to the absence of effective alternatives. The State Office of Protection and Advocacy has pending litigation against DSS on behalf of institutionalized individuals with mental illness, for failing to provide more appropriate, community-based care. *Connecticut Office of Protection and Advocacy for Persons with Disabilities v. State of Connecticut*, No. 3:06CV00179 (D. Conn.).

¹⁹ The State Long-Term Care Planning Committee projects that Connecticut's older adult population is expected to grow **by 25%** by 2025, compared to projected general population growth of 3% for the same period. Long Term Care Plan, p. 42

Moreover, many of the community-based care options referenced by the State are more accurately described as pilot programs right now, rather than viable, alternative sources of care. Even the State recognizes that expanding the range of community-based care will require significant “changes to federal Medicaid law that will facilitate an expansion of home and community-based options” – changes that obviously have not yet taken place. *Id.* at 72 (CA76).²⁰

Right now, it is the continued viability of nursing homes – critically threatened by Section 32’s freeze of Medicaid rates – that allows other providers along the continuum to provide accessible, lower-cost care, secure in the

(CA46). The population of people over 65 with disabilities is expected to increase **by 60%** by 2025. *Id.* at 43 (CA47).

²⁰ Only limited Medicaid funding is available for assisted living services, for example. Federal law prohibits Medicaid from covering assisted living services, unless the state applies for and receives a special waiver. Connecticut has not received such a waiver. As a result, Medicaid funding for assisted living is not generally available in Connecticut other than through a few special programs that cover a limited number of people. For the handful who qualify for these programs, Medicaid support is restricted to assisted living services; these individuals do not receive Medicaid support for room and board, which in many cases represents the largest percentage of costs. As a result, individuals who cannot afford to stay and pay privately in assisted living have few options other than to go to a nursing home. Similarly the “Money Follows the Person Program” that is often cited by the State has taken time to implement, transitioning only 138 individuals from nursing homes into community settings as of November 2009. Long Term Care Plan, p. 7 (CA11). While these programs may have some impact in the future on nursing home occupancy levels, for many frail, elderly citizens of this state, nursing homes remain the only option. That nursing homes may diminish in number at some point in the distant future does not excuse the state from adequately funding the vital services that they provide.

knowledge that if a patient or resident becomes more acutely ill or debilitated, the nursing home is there to provide the more extensive services needed. In addition, nursing homes provide essential post-acute services, allowing for earlier, safer discharge from hospitals into a more home-like setting to assure rehabilitation and avoidance of readmission to the hospital. See Long Term Care Plan at 33 (CA37). ("In addition to serving long-term care needs, nursing facilities are relied upon for short term post-acute rehabilitation services.")

CANPFA represents not only nursing homes, but other types of facilities providing the continuum of care for the elderly and the chronically ill. For the most part, those facilities are interconnected. Only eight of the forty-eight CANPFA nursing homes are free-standing; the rest are physically, financially and operationally integrated with continuing care retirement communities, home and community-based services, and hospitals and health care systems. The demise of a nursing home because of chronic Medicaid underfunding by the State thus not only threatens the nursing home, but could also weaken other organizations that provide services along the continuum of care.

Under these circumstances, the absence of a preliminary injunction to prevent the State from implementing further rate reductions under Section 32 would irreparably harm nursing homes, their residents, and the communities they serve. The industry is at a tipping point – it makes no sense to wait to act until

more homes are in costly receiverships, bankruptcies, or closure proceedings and other homes have incurred additional losses that they cannot recover.

CONCLUSION

For the reasons set forth above, CANPFA respectfully submits that the District Court's decision should be reversed and remanded with instructions to grant CAHCF's motion for preliminary injunction.

Respectfully submitted,

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s/Aaron S. Bayer

Aaron S. Bayer

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I hereby certify that, on August 9, 2010, the Brief of *Amicus Curiae* Connecticut Association of Not-For-Profit Providers for the Aging in Support of Plaintiff-Appellant, was filed electronically in CM/ECF, and the original and five (5) copies of the brief were mailed via FedEx Priority Overnight to:

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