

10-2237-CV

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; and
MICHAEL P. STARKOWSKI, Commissioner of Social Services,
Defendants-Appellees.

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

**REPLY BRIEF FOR PLAINTIFF-APPELLANT
CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC.**

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PRELIMINARY STATEMENT

At its most basic level, this appeal presents a relatively straightforward question of statutory interpretation, which this Court reviews *de novo*. The parties agree that under 42 U.S.C. § 1396a(a)(30)(A) (“§ 30(A)”), a State’s plan for medical assistance must include such payment methods as may be necessary to “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” The parties radically disagree about what these words mean.

According to Defendants-Appellees M. Jodi Rell and Michael P. Starkowski (collectively, “Governor Rell”), § 30(A)’s “only” substantive requirement is that “Medicaid beneficiaries have equal access to efficient, economic, and quality care.” Rell Br. at 3; *see also id.* at 20 (arguing that “equal access to quality nursing facility services” is “all that the statute requires”), 23 (arguing that “equal access to quality services” is § 30(A)’s “sole” requirement). That is incorrect. While Plaintiff-Appellant Connecticut Association of Health Care Facilities, Inc. (“CAHCF”) agrees that equality of access is an important aspect of § 30(A), Governor Rell’s myopic focus on

equality of access ignores the plain language of the statute, which provides that a state plan must also include such payment methods as may be necessary to “assure that payments are consistent with efficiency, economy, and quality of care”

What, then, does it mean to “assure that payments are consistent with efficiency, economy, and quality of care”? Governor Rell never provides an answer. Instead, she argues that whatever else § 30(A) may require, the actual cost of what it takes to provide quality care in an efficient manner is irrelevant. *See* Rell Br. at 49-53. Therefore, in her opinion, it is of no moment that Connecticut’s payment methodology for nursing facility services, as most recently amended by section 32 of Connecticut Public Act 09-5 (“§ 32”), produces payment rates that are completely divorced from the actual cost of providing quality care in an efficient manner. That, too, is incorrect.

As the Secretary of Health and Human Services (“Secretary”) and the Centers for Medicare & Medicaid Services (“CMS”) have explained, for payment rates to be consistent with efficiency, economy and quality of care, “they must bear a reasonable relationship to provider costs.” Br. for Resp’ts at 32, *Alaska Dep’t of Health & Soc. Servs. v. CMS*, No. 04-74204 (9th

Cir. Dec. 27, 2004), JA 868 (“CMS *Alaska Br.*”) (quoting *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1499 (9th Cir. 1997)); accord *Br. for Resp’ts at 35, Minnesota v. CMS*, No. 06-3263 (8th Cir. Dec. 18, 2006), JA 917 (“CMS *Minnesota Br.*”) (explaining that § 30(A)’s use of the word “efficiency” means “effective operation as measured by a comparison of production with cost”). In other words, a State’s payment methodology must “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.” *CMS Alaska Br.* at 32, JA 868. There is no question that Connecticut’s statutory payment methodology conflicts with that standard. The record demonstrates that each year, the exigencies of the state budgetary process take precedence over what is necessary to assure that payments are consistent with efficiency, economy and quality of care, so that such factors are never even considered.

That is not to say that § 30(A) creates an inflexible standard depriving States of significant discretion in setting payment rates. Far from it. By enacting § 30(A), “Congress intended payments to be flexible within a range; payments should be no higher than what is required to provide efficient and economical care, but still high enough to provide for quality care and to en-

sure access to services.” *Orthopaedic Hospital*, 103 F.3d at 1497. By enacting a flexible standard, however, Congress did not give States unfettered discretion to enact statutes that conflict with the commands of federal law, as Connecticut has done here.

Because the district court’s decision denying CAHCF’s motion for a preliminary injunction was based on the same flawed statutory interpretation advocated by Governor Rell, this Court should reverse the district court’s judgment and grant CAHCF preliminary injunctive relief pending the outcome of proceedings on remand.

ARGUMENT

I. The District Court Erred In Denying CAHCF’s Motion For A Preliminary Injunction Based On Count I Of The Complaint

A. The Law Of This Circuit Does Not Allow States To Set Payment Rates Based Solely On State Budgetary Concerns

In its opening brief, CAHCF explained that the district court erred in holding that States can set payment rates based solely on state budgetary concerns. *See* CAHCF Br. at 42-46. Governor Rell’s response has four principal components, each of which should be rejected.

First, Governor Rell incorrectly argues that the district court did not actually decide that States can set payment rates based solely on state budg-

etary concerns. Rell Br. at 42. Count I of CAHCF's complaint alleged that Connecticut established payment rates "based solely on state budgetary factors." Compl. ¶ 179, JA 66. Accepting that allegation as true, the district court not only denied CAHCF's motion for a preliminary injunction with respect to Count I, it also dismissed Count I in its entirety. *Conn. Ass'n of Health Care Facilities v. Rell*, No. 3:10-cv-136, 2010 WL 2232693, at *9 (D. Conn. June 3, 2010), SPA 11 ("CAHCF I"). In doing so, the district court held that it would not evaluate the "legislative or administrative process" by which the State set payment rates, thereby leaving the State free to set payment rates based solely on state budgetary concerns. *Id.*

Second, Governor Rell mistakenly suggests that this Court has authorized States to establish payment rates based solely on state budgetary concerns. *See* Rell Br. at 45. In support of her argument, Governor Rell cites this Court's decision in *New York Ass'n of Homes & Services for the Aging v. DeBuono*, 444 F.3d 147 (2d Cir. 2006) (per curiam), which summarily affirmed *In re NYAHSAs Litigation*, 318 F. Supp. 2d 30 (N.D.N.Y. 2004). *NYAHSAs* involved an attempt by Medicaid providers to enforce various provisions of the Medicaid Act using 42 U.S.C. § 1983. *See* 318 F. Supp. 2d at 32. The providers also asserted certain constitutional claims. *See id.* In the con-

text of rejecting the plaintiffs' substantive due process claim, the district court in *NYAHS*A observed that controlling Medicaid costs was a "legitimate and laudable objective of the State." *Id.* at 41. The district court's decision contains no language suggesting that state budgetary concerns may trump § 30(A)'s command that a State must assure its Medicaid payments are consistent with efficiency, economy, quality of care and equality of access.

Third, according to Governor Rell, the budgetary motives of state actors are "at their weakest" in the context of a preemption challenge. Rell Br. at 46. However, neither of the decisions Governor Rell cites suggests that a court must confine itself to the face of a state statute in order to determine whether that statute stands as an obstacle to the accomplishment of the full purposes and objectives of federal law. *See Hughes v. Oklahoma*, 441 U.S. 322, 336 (1979) (explaining that in considering a state statute's purpose, courts are not "bound" by the "name, description or characterization" given to it by the state legislature); *Lacoste v. Dep't of Conservation of La.*, 263 U.S. 545, 550 (1924) (explaining that the "name, description or characterization" given by a state legislature does not "control"). Where, as here, a state legislature assumes responsibility for setting Medicaid payment rates instead of delegating that task to agency officials, it is fully appropriate for a

court to evaluate the legislative process leading to a statute's enactment, which serves as the functional equivalent of the administrative record. *Cf. Wallace v. Jaffree*, 472 U.S. 38, 56-57 (1985) (evaluating legislative record in determining state statute's true purpose); *Jones v. Rath Packing Co.*, 430 U.S. 519, 526 (1977) (explaining that conflict preemption requires a court "to consider the relationship between state and federal laws as they are interpreted and applied, not merely as they are written").

Fourth, Governor Rell argues that "the State" actually considered the § 30(A) factors, such that budgetary concerns were not the sole reason for § 32's enactment. *See* Rell Br. at 47-48. Governor Rell then cites the affidavits submitted by certain state agency officials. Rell Br. at 48. Tellingly, Governor Rell cannot, and does not, cite one piece of specific evidence from the legislative record indicating that the General Assembly considered the § 30(A) factors of efficiency, economy, quality of care and equality of access, which is fatal to her argument. *See Cal. Pharmacists Ass'n v. Maxwell-Jolly*, 596 F.3d 1098, 1106-07 (9th Cir. 2010) (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"), *petition for cert.*

filed, 78 U.S.L.W. 3581 (U.S. Mar. 24, 2010) (No. 09-1158); *Ark. Med. Soc’y v. Reynolds*, 6 F.3d 519, 530 (8th Cir. 1993) (holding that States must actually consider the § 30(A) factors when setting payment rates); *Ohio Hosp. Ass’n v. Ohio Dep’t of Human Servs.*, 579 N.E.2d 695, 699 (Ohio 1991) (finding that reduction in Medicaid rates violated § 30(A) because it was implemented “without consideration of its effect on the quality of care provided by the Medicaid program”).

Contrary to Governor Rell’s argument, CAHCF does not ask this Court to “peer into the minds of dozens of agency officials and hundreds of legislators and decide if budgetary concerns played a minor, major, or exclusive role in their final decision in order to determine whether a state law is in actual conflict with federal law.” Rell Br. at 48. All that CAHCF asks is that the Court evaluate the written legislative record assembled in this case, which overwhelmingly demonstrates that the General Assembly enacted § 32 for one purpose and one purpose only: to cut state spending.

B. The Law Of This Circuit Does Not Allow States To Ignore The § 30(A) Factors When Setting Payment Rates

CAHCF’s opening brief explained that the district court erred in holding that, as a matter of law, States can ignore the statutory factors of efficiency, economy, quality of care and equality of access when setting payment

rates. *See* CAHCF Br. at 42-48. Repeating an argument she made in the district court, Governor Rell contends that this Court’s “precedents” confirm that § 30(A) does not impose any procedural requirements. Rell Br. at 36. In support of her argument, Governor Rell again cites *NYAHS*A for a holding it does not contain.

Like most of the § 30(A) cases Governor Rell cites, *NYAHS*A involved an attempt by Medicaid providers to enforce various provisions of the Medicaid Act using § 1983. *See* 318 F. Supp. 2d at 32. In rejecting the providers’ challenge, the district court explained that § 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.” *Id.* at 32. The aspect of *NYAHS*A upon which Governor Rell relies found that § 30(A) does not confer federal “rights” on Medicaid providers that are enforceable under § 1983. *See id.* at 39-40.

Importantly, *NYAHS*A did not involve claims for injunctive relief under the Supremacy Clause. As a result, a long line of precedent demonstrates that *NYAHS*A’s holding with respect to § 1983 has no bearing on CAHCF’s Supremacy Clause claims. *See, e.g., Loyal Tire & Auto Ctrs., Inc.*

v. Town of Woodbury, 445 F.3d 136, 149 (2d Cir. 2006) (explaining difference between § 1983 claims and claims for injunctive relief rooted in the Supremacy Clause); *Village of Westfield v. Welch's*, 170 F.3d 116, 124 n.4 (2d Cir. 1999) (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]”); *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050, 1063 (9th Cir. 2008) (rejecting argument identical to that made by Governor Rell), *cert. denied sub nom. Maxwell-Jolly v. Indep. Living Ctr. of S. Cal., Inc.*, 129 S. Ct. 2828 (2009).

Therefore, the district court properly rejected Governor Rell’s argument. *See CAHCF I*, 2010 WL 2232693, at *8, SPA 10 (finding that whether § 30(A) imposes any procedural requirements is a legal question undecided by this Court).

C. The District Court’s Legal Holding That Cost Is Irrelevant Conflicts With The Most Recent Appellate Decisions To Have Decided The Issue And With CMS’s Well-Established Interpretation Of § 30(A)

Governor Rell concedes that the district court’s legal holding that States can ignore how much it actually costs to provide quality care in an efficient manner conflicts with the most recent appellate decisions to have decided the issue. *See Rell Br.* at 38-39. She nonetheless argues that this

Court should reject those authorities and adopt what she contends was the interpretation of § 30(A) advocated by an *amicus* brief filed by the Solicitor General in 1997. *See id.* at 39-42. Governor Rell misinterprets the Solicitor General's *amicus* brief, which has since been superseded.

As an initial matter, the law of this Circuit provides 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 (2d Cir. 2006). 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.* at 239-40 (quoting *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944)).

In its opening brief (at 50 n.2), CAHCF explained that, in advising the Supreme Court *not* to review the Ninth Circuit's decision in *Orthopaedic Hospital*, an *amicus* brief filed by the Solicitor General disagreed with certain aspects of the Ninth Circuit's ruling, particularly language that the Solicitor General believed suggested that § 30(A) required payment rates to reimburse providers for their *full* costs regardless of efficiency and econ-

omy—an interpretation of § 30(A) CAHCF has specifically disavowed. *See* Br. for United States as *Amicus Curiae* at 3, 6-8, *Belshe v. Orthopaedic Hosp.*, No. 96-1742 (U.S. Nov. 26, 1997), JA 660, 663-65. CAHCF then explained that more recent appellate briefs filed by CMS supported CAHCF's interpretation of § 30(A). *See* CAHCF Br. at 50-52 (discussing *Alaska Dep't of Health & Soc. Servs. v. CMS*, 424 F.3d 931 (9th Cir. 2005), and *Minnesota v. CMS*, 495 F.3d 991 (8th Cir. 2007)).

In response, Governor Rell contends that, because the Solicitor General's brief purports to express the views of the Secretary, it should be given priority over the more recent briefs filed in *Alaska* and *Minnesota*, which she incorrectly suggests only represent the views of CMS. *See* Rell Br. at 34-35. While CMS was the first-listed respondent in *Alaska* and *Minnesota*, the briefs in both cases were filed on behalf of the Secretary *and* CMS. *See* JA 880, 943.

Governor Rell also seeks to marginalize the interpretation of § 30(A) announced in *Alaska* and *Minnesota* on the basis that, unlike here, both of those cases involved situations where States were seeking to increase their payment rates. *See* Rell Br. at 34-35. That, however, is a distinction without a difference under the plain language of § 30(A). Section 30(A) is a founda-

tional minimum that admits no exceptions, requiring States “to *assure* that payments are consistent with efficiency, economy, and quality of care” and equality of access. § 30(A) (emphasis added). In demanding that States *assure* achievement of these statutory goals, § 30(A) commands a high degree of certainty that the statutory goals will be achieved. *See* American Heritage Dictionary 136 (2d College ed. 1982) (defining “assure” as “[t]o inform confidently, with a view to removing doubt” and “[t]o make certain”); Black’s Law Dictionary 144 (9th ed. 2009) (defining “assurance” as “[s]omething that gives confidence”).

In *Alaska*, for example, the brief filed by the Secretary and CMS specifically explained that § 30(A) “ensures 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*)” CMS *Alaska* Br. at 36, JA 872 (emphasis added). Thus, contrary to Governor Rell’s argument, the Secretary and CMS have explained that § 30(A)’s “consistent with efficiency, economy, and quality of care” language also serves to ensure that state payment methodologies do not produce payment rates that are too low.

Without substantive explanation, Governor Rell also seeks to marginalize the briefs filed in *Alaska* and *Minnesota* by noting that they cite the

Third Circuit's splintered decision in *Pennsylvania Pharmacists Ass'n v. Houstoun*, 283 F.3d 531 (3d Cir. 2002) (in banc), in which the majority held that § 30(A) does not create "rights" enforceable by providers under § 1983. Rell Br. at 35. Not only is the § 1983 question not before this Court (*see* Section I.B, *supra*), to the extent that merely citing a decision reflects an endorsement of its holding, it is telling that the *Alaska* brief block-quotes an entire section of *Orthopaedic Hospital* in support of the proposition that for payment rates to be consistent with efficiency, economy and quality of care, they must bear a reasonable relationship to provider costs. CMS *Alaska* Br. at 32, JA 868. Moreover, neither brief cites the principal decision on which Governor Rell relies, *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026 (7th Cir. 1996). *See* Rell Br. at 37, 51. *But see* CAHCF Br. at 47-48 (distinguishing *Methodist Hospitals*, which only addressed § 30(A)'s equality-of-access language); *Rite Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842, 851-52 (3d Cir. 1999) (rejecting logic of *Methodist Hospitals*).

According to Governor Rell, the First and Fifth Circuits "also rejected the interpretation that Section 30(A) requires States to study provider costs, or even that States must specifically analyze the impact of a contemplated payment adjustment on the factors specified in Section 30(A) before they can

change their Medicaid reimbursement levels.” Rell Br. at 37-38 (citing *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 56 (1st Cir. 2004), and *Evergreen Presbyterian Ministries v. Hood*, 235 F.3d 908, 933 n.33 (5th Cir. 2000)). What Governor Rell neglects to mention is that *Long Term Care Pharmacy* and *Evergreen* both involved challenges limited to § 30(A)’s equality-of-access requirement and whether it created “rights” enforceable under § 1983. See *Long Term Care Pharmacy*, 362 F.3d at 53; *Evergreen*, 235 F.3d at 927 n.24. Far from suggesting that cost data is irrelevant, the First Circuit chastised the plaintiffs for refusing to give state officials the cost information they needed. See *Long Term Care Pharmacy*, 362 F.3d at 59. Moreover, as in *Methodist Hospitals* (and unlike here), the record in *Long Term Care Pharmacy* demonstrated that state officials carefully studied the rate changes prior to their implementation after federal officials informed the State it was paying above-market prices for certain drugs. See *id.* at 52.

Nor is Governor Rell correct in asserting that “it would be an exercise in futility to require States to ascertain the costs of the thousands of different procedures for which Medicaid provides reimbursement.” Rell Br. at 31. As reflected by the annual cost-reporting requirements already imposed by the State on nursing facilities, States are fully capable of acquiring, and Con-

necticut already does acquire, cost information or proxies for such information. *See* CAHCF Br. at 9; *see also* Conn. Gen. Stat. §§ 17b-232 (requiring cost-based reimbursement for private boarding homes), 17b-238 (requiring hospitals to submit cost data), 17b-242(b) (requiring home health agencies to submit cost data), 17b-243 (requiring that payments to rehabilitation centers be updated “to reflect necessary increases in the cost of services”), 17b-274a (establishing cost-based payment methodology for generic prescription drugs).

Finally, Governor Rell asserts that § 30(A) “affords no basis for a claim that a State’s failure to study or reimburse costs ‘conflicts’ with [§ 30(A)’s] terms.” Rell Br. at 31. To the extent this offhand remark is intended as an attack on the ability of CAHCF to assert a cognizable claim of conflict preemption as it relates to a state statute and § 30(A), such an undeveloped argument fails to adequately present that issue for this Court’s consideration. *See Tolbert v. Queens College*, 242 F.3d 58, 75 (2d Cir. 2001) (refusing to address appellee’s undeveloped legal argument). Furthermore, any such argument was rightly rejected by the district court as being inconsistent with the law of this Circuit. *See CAHCF I*, 2010 WL 2232693, at *7, SPA 9 (citing *Catholic Med. Ctr. of Brooklyn & Queens, Inc. v. Rockefeller*, 430 F.2d 1297

(2d Cir. 1970) (per curiam), and *Pharmacists Soc’y of the State of N.Y. v. N.Y. Dep’t of Soc. Servs.*, 50 F.3d 1168 (2d Cir. 1995)).

D. The Law Of This Circuit Provides That The Boren Amendment’s Legislative History Is Irrelevant To The Meaning Of § 30(A)

CAHCF’s opening brief explained in detail why the district court erred in basing its interpretation of § 30(A) on legislative history related to the 1997 repeal of the Boren Amendment. *See* CAHCF Br. at 52-55. As this Court has already held, § 30(A) “was not affected by repeal of the Boren Amendment.” *NYAHS*A, 318 F. Supp. 2d at 32, *aff’d per curiam*, 444 F.3d at 148; *see also Orthopaedic Hospital*, 103 F.3d at 1499 (rejecting argument that interpreting § 30(A) as imposing procedural requirements would render the Boren Amendment “superfluous”). Despite that fact, Governor Rell continues to advocate this illogical approach, which has also been rejected by federal officials and the Ninth Circuit. *Compare* Rell Br. at 26-39, *with Alaska*, 424 F.3d at 941; *CMS Alaska* Br. at 36, JA 872; *CMS Minnesota* Br. at 38, JA 920.

In particular, Governor Rell cites a single statement in one committee report that she contends reflects congressional intent to implicitly alter § 30(A)’s meaning. *See* Rell Br. at 28. The committee report opined that

following the enactment of legislation repealing the Boren Amendment, neither it “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). *But see* H.R. Rep. No. 105-217, at 868 (1997) (Conf. Rep.) (containing no such statement in describing legislative intent for repealing Boren Amendment), *as reprinted in* 1997 U.S.C.C.A.N. 176, 489.

“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” legislation giving § 30(A) its current form. *Vt. Agency of Natural Res. v. United States ex rel. Stevens*, 529 U.S. 765, 783 n.12 (2000); *see also Rabin v. Wilson-Coker*, 362 F.3d 190, 198 (2d Cir. 2004) (rejecting district court’s reliance on purposes served by later-enacted legislation because it did not amend the Medicaid Act provision at issue, which this Court was unwilling to assume Congress modified by implication). Even if it were relevant, the committee report’s offhand comment that no provision of § 1396a should be “interpreted as establishing a cause of action” does not affect the validity of CAHCF’s Supremacy Clause claims. Those claims do not look to § 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).

II. The District Court Erred In Denying CAHCF's Motion For A Preliminary Injunction Based On Count II Of The Complaint

A. The Law Of This Circuit Does Not Support Governor Rell

Governor Rell claims that this Court's "precedents" provide that § 30(A) does not require payment rates to be reasonably related to the cost of providing quality care in an efficient and economic manner. Rell Br. at 50. That is incorrect. Governor Rell bases her argument on the very same aspects of *NYAHSA* related to the federal "rights" question under § 1983, none of which addressed the cost issue. *See* Rell Br. at 49-50. If anything, language in the district court's decision supports CAHCF, not Governor Rell. In relevant part, the district court explained that § 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." 318 F. Supp. 2d at 32. "[W]hat is needed by facilities to maintain efficient, economic, and quality care"? Payments bearing a reasonable relationship to the cost of providing quality care in an economic and efficient manner.

The plain language of § 30(A) also provides that Medicaid payments must be consistent with quality of care. Without citing any factual evidence, Governor Rell contends that the State's payment methodology is responsible for producing "an abundance of high quality nursing homes willing to serve Medicaid patients." Rell Br. at 7. She goes on to explain that in order to participate in Medicaid, nursing facilities must agree to comply with the Medicaid Act's stringent quality-of-care standards. *Id.* However, simply because nursing facilities meet stringent quality-of-care standards does not mean that Connecticut's payment methodology can be given credit for that fact. Instead, the record reflects that CAHCF's members are able to provide quality care only because of payment sources other than Medicaid, which cross-subsidize Connecticut's deficient Medicaid rates. *See* Lubarsky Decl. ¶ 34, JA 552; *LPRI Report* at 1, JA 295; *see also Orthopaedic Hospital*, 103 F.3d at 1497 (explaining that under the plain language of § 30(A), "payments themselves must be consistent with quality care," such that de facto quality of care caused by regulatory obligations imposed on providers to deliver such care is insufficient).

B. The District Court Erred In Giving “Considerable Deference” To CMS’s Cursory Approval Letter

In its opening brief (at 63-65), CAHCF explained that the law of this Circuit provides that in “assessing the reasonableness of CMS’s decision” approving a state plan amendment, a district court should “consider the materials submitted by [the State] in support of its plan, and the factors considered by CMS in evaluating those materials.” *Cnty. Health Ctr. v. Wilson-Coker*, 311 F.3d 132, 140 (2d Cir. 2002). Because the district court in this case did neither of those things, and because the record reflects that, if it had, the district court should have given CMS’s one-page approval letter no deference, CAHCF argued that the district court erred in giving CMS’s approval letter “considerable deference.” *CAHCF I*, 2010 WL 2232693, at *10, SPA 12.

Governor Rell makes no effort to demonstrate that the district court did what this Court instructed in *Community Health Center*. Instead, she tries to distinguish certain other cases cited by CAHCF that demonstrate courts regularly refuse to give cursory state plan amendment approval letters any deference. For example, Governor Rell argues that certain of the decisions cited by CAHCF are distinguishable merely because they involved a provision of the Medicaid Act other than § 30(A). *See* Rell Br. at 56 (citing

Pinnacle Nursing Home v. Axelrod, 719 F. Supp. 1173 (W.D.N.Y. 1989), *aff'd*, 928 F.2d 1306 (2d Cir. 1991); *Ill. Health Care Ass'n v. Bradley*, 983 F.2d 1460 (7th Cir. 1993); and *Neb. Health Care Ass'n v. Dunning*, 778 F.2d 1291 (8th Cir. 1986)). Her argument overlooks the fact that these cases involved the same general administrative process that Governor Rell contends should be given considerable deference in this case. Furthermore, although she claims that the States in those other cases admitted that they failed to undertake the analysis the courts believed was required, the same would be true in this case if the Court reverses the district court's faulty interpretation of § 30(A).

III. The District Court's Public Interest Finding Does Not Withstand Careful Scrutiny

In denying CAHCF's second request for preliminary injunctive relief, the district court focused entirely on what it perceived the ramifications of granting such relief would be on the State. "[I]n light of the difficult economic times and the [General Assembly's] expertise in fiscal and budgetary arenas," the district court believed it was "against the public interest for the Court to enjoin Section 32 and force [the State] to make other administrative and budgetary cuts." *Conn. Ass'n of Health Care Facilities v. Starkowski*, No. 3:10-cv-136, slip op. at 2 (D. Conn. June 15, 2010), SPA 16-17.

In its opening brief, CAHCF explained that the record in this case demonstrates that the district court uncritically accepted Governor Rell's argument that granting CAHCF preliminary injunctive relief would require drastic reorganization of the State's entire budget, which argument also cannot be reconciled with Governor Rell's most recent public statements. *See* CAHCF Br. at 66. Choosing to ignore her most recent public statements, Governor Rell contends that the district court did not err in finding that a preliminary injunction would harm the public interest. Rell Br. at 57. However, her limited view of what is or is not in the public interest is not dispositive. 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.

"A budget crisis does not excuse ongoing violations of federal law, particularly when there are no adequate remedies available other than an injunction." *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644, 658-59 (9th Cir. 2009), *petition for cert. filed*, 78 U.S.L.W. 3500 (U.S. Feb. 16, 2010) (No. 09-958), *views of the Solicitor Gen. called for*, 78 U.S.L.W. 3687 (U.S. May 24, 2010). 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 effectively allows States to accept billions of dollars in federal funds while disregarding federal legal requirements when circumstances make compliance more difficult 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 § 30(A) in order to receive billions of dollars in federal funds. That promise remains unfulfilled. *See Cal. Pharmacists Ass'n v. Maxwell-Jolly*, 563 F.3d 847, 852-53 (9th Cir. 2009) (per curiam) (finding it “would not be equitable or in the public’s interest to allow the state to continue to violate the requirements of” § 30(A) because the “interest of preserving the Supremacy Clause is paramount”).

Indeed, § 30(A) is a clear congressional recognition that, unless States assure that payments are consistent with efficiency, economy, quality of care and equality of access, health care providers cannot provide quality services to Medicaid beneficiaries and remain fiscally viable. Thus, in the Medicaid Act, Congress both created a benefit and, as a means to secure the delivery thereof, established payment standards that assure the private sector would be capable of delivering that benefit.

Without citing any factual evidence, Governor Rell also contends that “nothing prevents nursing facilities from adjusting their *actual* costs to compensate for declining revenues, as most businesses can be expected to do in tough economic times.” Rell Br. at 52 (emphasis in original). However, Governor Rell ignores the fact that nursing facilities are not like “most businesses,” especially in Connecticut. As explained in detail by the *amicus* brief filed by the Connecticut Association of Not-for-Profit Providers for the Aging (“CANPFA”), it is virtually impossible for nursing facilities to leave Connecticut’s Medicaid program voluntarily. CANPFA Br. at 11-12. Moreover, the majority of nursing facilities’ costs are for personnel and other expenses directly related to resident care. *Id.* at 13; *see also LPRI Report* at 15, JA 309 (explaining that providing care in nursing facilities is very labor-intensive, “with direct and indirect care staffing accounting for 75 percent of facility costs”). Given the exceedingly stringent quality-of-care requirements imposed on nursing facilities, “cutting back on staffing, quality and level of service is not a realistic option.” CANPFA Br. at 13.

As she did in the district court, Governor Rell also seeks to make much of the fact that Connecticut’s payment rates are higher than in certain other States. *See* Rell Br. at 7. The district court expressly rejected Governor

Rell's argument, with good reason. As the Eighth Circuit has explained, such a comparison has no bearing on efficiency, economy, quality of care and equality of access in the State under review. *Ark. Med. Soc'y v. Reynolds*, 6 F.3d 519, 530 (8th Cir. 1993). The district court found Governor Rell's argument unpersuasive because the "cost of providing care is higher in Connecticut than most states." *CAHCF I*, 2010 WL 2232693, at *11 n.9, SPA 13. The factual record supports the district court's finding. *See, e.g., LPRI Report* at 16-17, JA 310-11 (describing wage differences in Connecticut versus other States).

Governor Rell also points to the fact that certain nursing facilities in Connecticut may be able to eek out a profit in spite of the State's deficient Medicaid rates. *See Rell Br.* at 53. The Tenth Circuit rightly rejected a similar argument in *Kansas Health Care Ass'n v. Kansas Department of Social and Rehabilitation Services*, 31 F.3d 1536 (10th Cir. 1994). There, the appellate court explained that nursing facilities need not assert that they are "on the verge of going out of business in order to establish that they are suffering imminent and irreparable harm." *Id.* at 1544. The fact that some facilities can cross-subsidize Medicaid underreimbursement also did not undermine the plaintiffs' claim of injury from such underreimbursement. *Id.* at 1544

n.15. To accept the state officials' argument, the court of appeals explained, would mean that 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 against retroactive money damages. *See United States v. New York*, 708 F.2d 92, 93 (2d Cir. 1983) (per curiam).*

IV. The Court Should Grant CAHCF Preliminary Injunctive Relief Pending The Outcome Of Proceedings On Remand

Governor Rell does not challenge this Court's ability to grant CAHCF preliminary injunctive relief pending the outcome of proceedings on remand,

* Governor Rell dedicates four pages of her brief suggesting that the cost reports filed by certain nursing facilities contain excessive costs. *See Rell Br.* at 14-17. Even if that were true, it is completely irrelevant to the legal issues presented by this appeal. Among other things, Governor Rell neglects to point out that the payment methodology rendered moot by § 32 allows state officials to disallow costs they deem are excessive. *See, e.g., Richter Aff.* ¶ 38, JA 694 (describing difference between costs reported by facilities and "Medicaid allowable" costs); *Murphy Decl. Ex. A* at 3, JA 516 (rate computation report listing disallowed costs).

nor does she challenge CAHCF's assertion that its members will suffer irreparable harm in light of the State's Eleventh Amendment protection against retroactive money damages. Instead, Governor Rell argues against granting such relief because, if the injunction is later dissolved, recouping the extra amounts paid to nursing facilities would be "difficult to implement" in that doing so would "deprive facilities of the funds they need to operate going forward." Rell Br. at 58. In other words, Governor Rell contends that this Court should not grant preliminary injunctive relief because taking away funds from nursing facilities—something Governor Rell has already done by sponsoring and signing § 32—would place nursing facilities in "extreme financial jeopardy, and Medicaid recipients would be at risk of losing access to quality nursing home care." *Id.*

The Court should reject Governor Rell's illogical argument given that nursing facilities would only be placed in the same position they are now.

CONCLUSION

For the foregoing reasons, as well as those stated in CAHCF's opening brief and in CANPFA's *amicus* brief, the Court should reverse the district court's ruling and grant CAHCF preliminary injunctive relief pending the outcome of proceedings on remand.

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7)(C), the undersigned certifies that the Reply Brief for Plaintiff-Appellant Connecticut Association of Health Care Facilities, Inc. contains 6,108 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii). The brief also 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, roman typeface (14-point Century Expanded) using Microsoft Word 2003.

/s/ Malcolm J. Harkins III
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CERTIFICATE OF SERVICE

The undersigned certifies that on this sixteenth day of September, 2010, he caused the Reply Brief for Plaintiff-Appellant Connecticut Association of Health Care Facilities, Inc. to be filed electronically with the Court using the Case Management/Electronic Case Filing system, which will automatically serve notice of same upon the following counsel for Defendants-Appellees M. Jodi Rell and Michael P. Starkowski via electronic mail:

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The undersigned also certifies that on this sixteenth day of September, he caused six (6) true and correct copies of the reply brief to be transmitted to the Clerk of this Court by third-party commercial carrier. Two (2) true and correct copies of the brief were also transmitted to the above-listed counsel by third-party commercial carrier.

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