IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

GENERATIONS HEALTH CARE NETWORK, LLC, As Consulting company of: *

Generations at Applewood, LLC *

Generations at Columbus Park, Inc *

Generations at Elmwood Park, Inc *

Generations at Neighbors, LLC *

Generations Oakton Pavillion, LLC *

Generations at Regency, LLC *

Generations at Rock Island, LLC *

CARLYLE HEALTHCARE CENTER, INC., *

ST. VINCENT'S HOME, INC., *

CLINTON MANOR LIVING CENTER, INC. and *

EXTENDED CARE CLINICAL, LLC, As Consulting company of: *

Beecher Manor Nursing and Rehabilitation Center, *

Briar Place, Ltd., *

Chateau Village Nursing and Rehabilitation Center, *

Grasmere Place, LLC, *

Kensington Place Nursing and Rehabilitation Center, *

Lakewood Nursing and Rehabilitation Center, *

Lemont Nursing and Rehabilitation Center, *

Little Village, *

Prairie Manor Nursing and Nursing Rehabilitation Center, *

Rainbow Beach Nursing and Rehabilitation Center, *

Sheridan Shores Nursing and Rehabilitation Center, *

South Suburban Rehabilitation Center, *

Spring Creek, *

St. James Wellness & Villas, *

The Estates of Hyde Park, *

The Parc of Joliet, *

The Paramount of Oak Park, *

Tri-State Nursing and Rehabilitation Center, *

Wheaton Care Center, *

PLAINTIFFS, *

V. *

FELICIA F. NORWOOD, in her official capacity as the Director of the Illinois Department of Healthcare and Family Services, *

DEFENDANT. *

COMPLAINT FOR DECLARATORY JUDGMENT

I. PRELIMINARY STATEMENT

As a condition of receiving federal funds, the State of Illinois is required to operate the Medicaid program in compliance with the Social Security Act and implementing regulations, pursuant to 42 U.S.C. § 1396(c). This case concerns the failure of Defendant, Felicia F. Norwood ("Defendant"), the Director of the Illinois Department of Healthcare and Family Services ("HFS") to comply with her obligation to submit for approval to CMS Medicaid reimbursement rates for medical care provided to Medicaid beneficiaries in long-term care facilities and to issue public notice of such reimbursement rates to the public and interested parties in compliance with the Federal rules and regulations of the United States. The Defendant is directly responsible for providing a public process for determination of rate of payment under the plan for . . . nursing facility services . . . under which (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published, (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications, (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published. 42 U.S.C. § 1396a(a)(13)(A). The failures by the Defendant to grant Medicaid benefits to residents of skilled nursing facilities constitute violations of the Federal Medicaid Act and implementing regulations at 42 USC § 1396u-2, 42 C.F.R. § 438.10, and 42 USC § 1396(a), Section 1902(a)(37)(a)

II. JURISDICTION AND VENUE

Jurisdiction of this court is invoked to secure protection to redress the deprivation under color of state law, statute, custom and/or usage of a right, privilege and/or immunity guaranteed to Plaintiffs by United States Constitution and by 42 U.S.C. §1983 and other Acts

of Congress and is proper under 28 U.S.C. §§ 1331 and 1334(a)(3). Venue lies in this forum pursuant to 28 U.S.C. § 1391(e).

III. PARTIES

1. Generations Health Care Network, LLC, ("Generations"), is an Illinois limited liability company authorized to do business in Illinois. Generations provides consulting services to a network of skilled nursing home facilities in Illinois.

2. Carlyle Healthcare Center, Inc. ("Carlyle") is headquartered in Carlyle, Illinois. Carlyle owns and operates a twenty-four hour skilled nursing home facility located in the State of Illinois.

3. St. Vincent's Home, Inc. ("St. Vincent's") is headquartered in Quincy, Illinois. St. Vincent's owns and operates a twenty-four hour skilled nursing home facility located in the State of Illinois.

4. Clinton Manor Living Center, Inc. ("Clinton Manor") is headquartered in xx. Clinton Manor owns and operates a twenty-four hour skilled nursing home facility located in the State of Illinois. Clinton Manor provides care to disabled, elderly residents of Illinois and to developmentally disabled residents. Clinton Manor in this complaint is only acting on behalf of its residents who are disabled, elderly, and receive Medicaid benefits.

5. Extended Care Clinical, LLC ("Extended Care") is an Illinois limited liability company authorized to do business in Illinois. Extended Care owns and operates multiple twenty-four hour long-term care facilities providing nursing care services to residents of Illinois.

6. The Illinois Department of Healthcare and Family Services ("HFS") is the State of Illinois agency responsible for providing healthcare coverage for adults and children who qualify for Medicaid.

7. The Felicia F. Norwood, is the Director of the Illinois Department of Healthcare and Family Services ("HFS" or "Norwood" or "Defendant"), and at all times material to this Complaint acted under color of state law in administering the regulations, customs, policies, and practices material herein. She is sued in her official capacity only.

IV. STATEMENT OF FACTS

8. Medicaid is a voluntary, jointly funded federal-state program authorized by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v (2011) (the "Medicaid Act"). It is a cooperative federalism program that authorizes the federal government to provide funds to states that provide medical assistance to individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396.

9. The primary purpose of the Medicaid program is "to assist the poor, elderly, and disabled in obtaining medical care." *Long Term Care Pharm. Alliance v. Ferguson,* 362 F.3d 50, 51 (1st Cir. 2004). The Medicaid program is voluntary, however, once a state elects to participate, it must comply with the Medicaid Act's provisions and regulations. *See Wilder v. Virginia Hosp. Ass'n,* 496 U.S. 498, 502 (1990).

10. In order to participate in Medicaid, a state must submit a state plan for medical assistance to the Centers for Medicare and Medicaid Services ("CMS"), the Federal agency charged with administering the Medicaid Act. 42 U.S.C. § 1396a.

11. The state plan, which allows CMS to ensure the state's compliance with the Medicaid

Act, describes the nature and scope of the state's Medicaid program, including the policies and methods the state will use to set reimbursement rates for services provided by Medicaid participating health care providers. 42 C.F.R. §§ 430.10 and 447.201(b).

12. Under the state plan, the state must provide "the categorically needy" with the following mandatory services: 1) inpatient and outpatient hospital care; 2) physician's services; 3) medical and surgical dentist's services; 4) nurse midwife services; 5) pediatric and family nurse practitioner services; 6) federally qualified health center services; 7) laboratory and x-ray services; 8) rural health clinic services; 9) prenatal care; 10) family planning services; 11) skilled nursing facility services for persons over age 21; 12) home health care services for persons who are over age 21 and eligible for skilled nursing services; 13) early and periodic screening, diagnosis, and treatment for persons under age 21; and, 14) vaccines for children. 42 C.F.R. § 440.210.

13. The state may also provide services to the "medically needy", as Illinois does. If it does, the state plan must provide, at a minimum, reimbursement for the services detailed in 42 C.F.R. § 440.220.

14. States may also determine their own Medicaid eligibility standards for optional populations and may decide what optional services to cover, what payment levels to set, and what administrative and operative procedures to apply.

15. In Illinois, Medicaid will cover care to medically needy individuals at a skilled nursing facility for individuals 21 years of age or older, but require that a preadmission screening assessment is required. *See Attachment 3.1-A of Illinois State Plan Amendment.*

16. The Federal government and the states share responsibility for financing the Medicaid program. The Federal government matches state Medicaid spending at rates that vary by state per capita income.

17. The states' Medicaid programs reimburse health care providers directly for covered services. 42 C.F.R. § 430.0. States establish rates for reimbursement subject to the rate-setting requirements of the Medicaid Act.

18. The Medicaid Act requires, among other things, that a state plan include both procedural and substantive elements for setting rates and provides: "(A) for a public process for determination of rate of payment under the plan for . . . nursing facility services . . . under which (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published, (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications, (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published . . . 42 U.S.C. § 1396a(a)(13)(A). Thus, the Medicaid Act requires that the state plan must not only provide substantive standards for setting rates, but it must also provide for procedural protections in the rate-setting process.

19. States must also comply with 42 C.F.R. § 447.205, a companion regulation to 42 U.S.C. § 1396a(a)(13)(A). That regulation requires public notice of any significant proposed change in the methods and standards for setting payment rates for Medicaid services. *See N.C., Dep't of Human Resources, Div. of Med. Assistance v. United States Dep't of Health & Human Servs.*, 999 F.2d 767, 771 (4th Cir. 1993) ("The public notice requirements mandated by 42 C.F.R. § [] 447.205 . . . [are] not burdensome and provide important procedural protections to providers and beneficiaries under the Medicaid program.").

20. The Medicaid Act further requires that a state plan "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 assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist such 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." 42 U.S.C. § 1396a(a)(30)(A); *see also* 42 C.F.R. § 447.204.

21. Defendant has failed to provide or submit or disclose any methods and/or procedures used to assure that Medicaid rates and payments are efficient, economic, and assure that quality of care may be maintained at a sufficient level, and has failed to include and/or take into account in setting its payment and effective rate any standard of cost of living adjustment and/or cost of labor and/or wage increase with respect to labor costs.

22. Additionally, CMS has proposed to amend 42 C.F.R. § 447.203-.204 to require states to consider the following before changing their reimbursement rates for healthcare providers or rate-setting methodology: (1) "the extent to which enrollee needs are met"; (2) "the availability of care and providers"; (3) "changes in beneficiary utilization of covered services"; and (4) "input from beneficiaries and affected stakeholders in determining the extent of beneficiary access to the affected services and the impact the proposed rate change will have, if any, on continued services access."

23. Pursuant to 42 C.F.R. § 447.253, Defendant is required to obtain CMS approval on an at least annual basis Medicaid rates for long-term care services:

> § 447.253 Other requirements
>
> **(a)***State assurances.* In order to receive CMS approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to CMS that the requirements set forth in paragraphs (b) through (i) of

this section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.

(b)*Findings.* Whenever the Medicaid agency makes a change in its methods and standards, but not less often than **annually**, the agency must make the following findings:

(1) Payment rates.

(i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality of safety standards.

(iii) With respect to nursing facility services –

(C) The State establishes procedures under which the data and methodology used in establishing payment rates are made available to the public.

42 C.F.R. § 447.253 (emphasis added)

Illinois Medicaid Reimbursement Rates

24. In Illinois, long-term care facilities, such as Plaintiffs, receive a per diem reimbursement from HFS for Medicaid-related costs.

25. The per diem reimbursement paid to nursing facilities by HFS is a single, comprehensive payment per day, per resident of each particular facility established pursuant to a "reimbursement rate" which is the sum of three (3) separately calculated components: (1) support cost; (2) nursing cost; and (3) capital cost.

26. Illinois Admin. Code § 153.125 codifies Medicaid rate adjustments to long-term care facilities in Illinois. Illinois Admin. Code § 153.126 codifies Long Term Care Facility Medicaid Per Diem Adjustments

27. In January 1994, a "freeze" was placed on the methodology used to determine the Medicaid reimbursement rates for long-term care facilities. See, HFS website at https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/LTC.aspx:

"Reimbursement rates were frozen on January 18, 1994. Since implementation of the rate freeze, exceptions allow for adjustments to the facility per diem based upon specific changes in facility costs. These exceptions can be found at 89 Ill. Adm. Code 153.100. Additionally, facility rates have increased or decreased since the freeze based on statutory authority. The history of those increases or decreases can be found at 89 Ill. Adm. Code 153.125 and 153.126".

28. However, from time to time, the Illinois Assembly has proposed amendments to the rates provided to Medicaid recipients receiving nursing care services at a long-term care facility.[1]

29. Furthermore, Defendant has submitted requests for approval by CMS of certain amendments which effect its Medicaid reimbursement rates to long-term care facilities subsequent to the effective date of said amendments. Said amendments, such as amendment to Attachment 4.19-D of the Illinois State plan was effective on January 1, 2014, was not submitted to CMS for approval until March 31, 2014, and was approved by CMS on April 8, 2015 (said amendment proposed to implement a payment methodology for the reimbursement of nursing

[1] As examples: 1) on January 11, 2008, under 32 Ill. Reg. 535, it was announced that effective January 1, 2008, Section 153.125 was amended in order to allow support rates for nursing facilities to be computed using the most recent cost report on file with HFS no later than April 1, 2005, updated for inflation to January 1, 2006, and allowed for the cost reports to be audited and adjusted by HFS. Notice of this amendment was proposed after its effective date, was not previously published to the public or afforded an opportunity for comment by interested parties. In the January 11, 2008 notice of the amendment, it was stated that the reason for the emergency amendment was to comply with Proposed IL bill SB 783; 2) on July 12, 2013, under 37 Ill. Reg. 10529, it was announced that effective June 27, 2013, Section 153.126 was amended in that nursing rates for residents classified in Resource Utilization Groups IV (RUG_IV) PA1, PA2, BA1, and BA2, during the quarter ending March 31, 2012 shall be reduced by 10 percent; that nursing rates for residents in all other RUG-IV groups shall be reduced by 1 percent, and that facility rates for the support and capital components shall be reduced by 1.7 percent. It was further provided (on June 27, 2013) that on or after July 1, 2012, supported living facilities shall have rates reduced by 2.7 percent. While notice for this amendment of Section 153.126 (37 Ill. Reg. 10529) was published in the Illinois Register (37 Ill. Reg. 1112), it was published on February 1, 2013, after the effective date of change; 3) on May 15, 2015, under 39 Ill. Reg. 6956, it was announced that effective May 1, 2015 through June 30, 2015, reimbursement rates for residents in skilled nursing facilities would be reduced by 12.6 percent from the rates in effect on April 30, 2015. Notice of amendment (29 Ill. Reg. 6956), proposed after its effective date, was not previously published to the public or afforded an opportunity for comment by interested parties. In the May 15, 2015 notice of the amendment, it was stated that "the adoption of this emergency rulemaking is deemed to be necessary for the public interest, safety, and welfare".

services provided in nursing facilities using a classification scheme and weights published by CMS); and amendment to Attachment 4.19D of the Illinois State plan was effective October 1, 2009, was not submitted to CMS for approval until November 24, 2009, and was approved by CMS on December 2, 2011 (said amendment allowed the State to claim for allowable costs paid by county-owned and operated nursing facilities in excess of the reimbursement received by the nursing facility and created a separate per diem reimbursement for ventilator dependent residents in all nursing facilities).

30. Upon belief, Defendant did not publish notice of the proposed amendments to the Illinois State Plan contained in proposed amendment to Attachment 4.19-D of the Illinois State plan, submitted to CMS on November 24, 2009 or April 8, 2015 and including multiple other amendments to the State Plan which affect the Medicaid rate afforded to long-term care facilities, such as Plaintiffs.

31. At no time did Defendant submit to CMS for approval an annual Medicaid rate payment methodology, nor data to support that its proposed rates were reasonable and adequate to meet the costs that are incurred by efficient and economically operated providers, as required by 42 C.F.R. § 447.253.

32. HFS publishes on a quarterly basis a specific Medicaid rate that it assigns to each individual long-term care facility in Illinois. These rates are published on the HFS website at https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/LTC.aspx. No notice is given to the facilities or other interested parties, no opportunity for review and comment, no justification for its methodology and data. Furthermore, these rates published on a quarterly basis are not submitted to CMS for approval.

Adverse Impact of the Illinois Budget Upon Nursing Facilities and their Patients

33. The State's actions have effectively set reimbursement rates so low that the State will not be able to assure reimbursement rates consistent with efficiency, economy, and quality of care, and equal access to care and services in compliance with the Medicaid Act.

34. The Plaintiffs estimate that the financial impacts resulting from the circumstance referenced above during the next 12 months to have significant impact on its ability to provide adequate quality of care to those whom it provides nursing care services.

35. As a direct result of the State's reductions in Medicaid reimbursement rates and changes to its reimbursement methodologies, Plaintiffs have and/or have considered substantially limiting their participation in the Medicaid/Illinois Medical Assistance program for Long Term Care Services. These programs provide considerable services to Medicaid patients. Reductions to these services will necessarily reduce access to Medicaid patients. Effectively, this means that Medicaid patient access to nursing care services will be severely curtailed denying equal access to Medicaid patients.

36. As a direct result of the State's reductions in Medicaid reimbursement rates and changes to its reimbursement methodologies, Plaintiffs are considering reducing its Medicaid participation. Such reductions will result in decreased access to care for Medicaid patients and fewer nursing care services and programs for Medicaid patients.

V. CAUSES OF ACTION

COUNT I - Supremacy Clause, Facial Challenge, 42 U.S.C. § 1396a(b) and 42 C.F.R. § 430.12, Substantive Violation "rate freeze" and Ill. Admin. Code §§ 153.125 & 153.126, Rate Reimbursement Enactments

37. Plaintiffs specifically incorporate and realleges the allegations asserted in each of the preceding paragraphs, as if fully set forth herein.

38. "A preemption analysis requires an examination of congressional intent, and federal regulations have no less preemptive effect than federal statutes." *Community Pharms. Of Indiana, Inc. v. Indiana Family & Social Servs. Administration,* Case No. 1:11-cv-0893-TWP-DKL, slip op. at 5 (S.D. Ind. July 8, 2011) (citing *Fedlity Federal Savings & Loan Ass'n v. de la Cuesta,* 458 U.S. 141, 152-153 (1982)).

39. 42 U.S.C. § 1396a(b) and 42 C.F.R. § 430.12 require amendments to the State's Medicaid plan to be submitted and approved by CMS before going into effect.

40. 42 C.F.R. § 430.12 states in relevant part that: "The [state] plan must provide that it will be amended whenever necessary to reflect . . . (ii) Material changes in State law, organization, or policy, or in the State's operation of the Medicaid program."

41. Illinois' state plan includes this requirement.

42. Moreover, courts have held that "[t]he state plan must be amended to reflect changes in federal law or policy or material changes in state law, organization, policy, or operation of the state Medicaid program, and the amendments also must be submitted for [CMS] approval." *Oregon Ass'n of Homes for Aging, Inc. v. Oregon by & through Dep't of Human Resources,* 5 F.3d 1239, 1241 (8th Cir. 1993) (citing 42 C.F.R. § 430.12(c)); *See Community Pharms. Of Indiana, Inc.*, Case No. 1:11-cv-0893-TWP-DKL, slip op. at 5 (finding that State's conduct in implementing fee reduction prior to HHS's approval to be "premature and irreconcilable with federal Medicaid law and . . . therefore preempted by the Supremacy Clause of the United States Constitution").

43. "A law that effects a change in payment methods or standards without [CMS] approval is invalid." *Oregon Ass'n of Homes for Aging, Inc.,* 5 F.3d at 1241.

44 The "rate freeze" and Ill. Admin. Code §§ 153.125 & 153.126 effects a material change in the State's operation of the Medicaid program because it allows the State to reduce reimbursement rates solely for budgetary reasons. Accordingly, the "rate freeze" and Ill. Admin. Code §§ 153.125 & 153.126 constitutes a state plan amendment.

45. Each Rate Reduction Enactment effected a material change in the State's operation of the Medicaid program because it significantly reduced the reimbursement rate for Provider Plaintiffs and had a significant fiscal impact on them. Accordingly, each Rate Reduction Enactment constituted a state plan amendment.

46. The "rate freeze" and Ill. Admin. Code §§ 153.125 & 153.126, as amended, effect material changes in State law and in the State's operation of the Medicaid program because they allow the State to underfund the Medicaid program and effectively reduce reimbursement rates solely for budgetary reasons. Accordingly, the "rate freeze" and Ill. Admin. Code §§ 153.125 & 153.126, as amended, constitute a state plan amendment.

47. The "rate freeze" and Ill. Admin. Code §§ 153.125 & 153.126, as amended, qualify as state plan amendments, the State was required to obtain CMS approval before utilizing them.

48. On information and belief, the State never submitted the "rate freeze" and Ill. Admin. Code §§ 153.125 & 153.126 to CMS for approval as state plan amendments.

49. Accordingly, the "rate freeze" and Ill. Admin. Code §§ 153.125 & 153.126, as amended, are unenforceable and of no force and effect until they have been submitted to CMS as state plan amendments and CMS approves them. *See Oregon Ass'n of Homes for Aging, Inc.,* 5 F.3d at 1241; *Community Pharms. Of Indiana, Inc.,* Case No. 1:11-cv-0893-TWP-DKL, slip op. at 5.

50. As a consequence of the foregoing acts, Plaintiffs have suffered and will continue to suffer irreparable harm.

COUNT II - 42 U.S.C. § 1983, 42 U.S.C. § 1396a(a)(13)(A) and 42 C.F.R. § 447.205, Rate Reduction Enactments

51. Plaintiffs specifically incorporate and reallege the allegations asserted in each of the preceding paragraphs, as if fully set forth herein.

52. Section 1396a(a)(13)(A) and 42 C.F.R. § 447.205 confer rights, privileges, or immunities on Medicaid-participating long-term care facilities and Medicaid recipients that are enforceable under 42 U.S.C. § 1983.

53. Section 1396a(a)(13)(A) of the Medicaid Act requires States to provide "a public process for determination of rates of payment under the [state] plan for hospital services . . . under which: (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published; (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications; (iii) final rates, the methodologies underlying the establishment of such rates, and justifications; and (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published.

54. 42 C.F.R. § 447.205 further requires public notice of any significant proposed change in the methods and standards for setting payment rates for Medicaid services. The content of the notice must: (1) describe the proposed change in methods and standards; (2) give an estimate of any expected increase or decrease in annual aggregate expenditures; (3) explain why the agency is changing its methods and standards; (4) identify a local agency in each county where

copies of the proposed changes are available for public review; (5) give an address where written comments may be sent and reviewed by the public; and (6) if there are public hearings, give the location, date and time for hearings or tell how this information may be obtained. The notice must then: (1) be published before the proposed effective date of the change; and (2) appear as a public announcement in one of the following publications: (i) the State register; (ii) the newspaper of widest circulation in each city with a population of 50,000 or more; or (iii) the newspaper of the widest circulation in the State, if there is no city with a population of 50,000 or more.

55. Under the state plan, the State further assured CMS that it had in place a public process that satisfied the above notice and comment requirements.

56. Nonetheless, the State promulgated the "rate freeze" and Ill. Admin. Code §§ 153.125 & 153.126, as amended, at issue in this case in violation of 42 U.S.C. § 1396a(a)(13)(A), 42 C.F.R. § 447.205, and the state plan. First, the State did not publish the proposed rate reductions and justifications for them prior to enacting them. Second, the State did not provide Plaintiffs with notice of the proposed rate reductions or a reasonable opportunity to review and comment on them. Third, in enacting each rate reduction, the State did not publish each rate reduction in accordance with 42 C.F.R. § 447.205(d). Fourth, the state did not consider or take into account the situation of disproportionate share hospitals in enacting each rate reduction.

57. Rather, the "rate freeze" and Ill. Admin. Code §§ 153.125 & 153.126, as amended, became law oftentimes effective **after** they were published publicly and effected significant reductions in reimbursement rates without affording Plaintiffs its rights under 42 U.S.C. § 1396a(a)(13)(A), 42 C.F.R. § 447.205, and the state plan.

58. Thus, the State's failure to comply with the requirements of 42 U.S.C. § 1396a(a)(13)(A), 42 C.F.R. § 447.205, and the state plan renders the "rate freeze" and Ill. Admin. Code §§ 153.125 & 153.126, as amended, unenforceable and of no force and effect.

59. As a consequence of the foregoing acts, the Plaintiffs will be irreparably harmed.

COUNT III - 42 U.S.C. § 1983, 42 U.S.C. § 1396a(a)(13)(A) and 42 C.F.R. § 447.205

60. Plaintiffs specifically incorporate and reallege the allegations asserted in each of the preceding paragraphs, as if fully set forth herein.

61. The State promulgated the "rate freeze" and Ill. Admin. Code §§ 153.125 & 153.126, as amended, in violation of 42 U.S.C. § 1396a(a)(13)(A), 42 C.F.R. § 447.205, and the state plan. First, the State did not publish its justifications for proposing to long-term care Medicaid rate reimbursement payments (effecting a rate reduction) and changing its rate-setting methodology. Second, the State did not provide Plaintiffs with notice of the proposed rate reductions and methodology changes or a reasonable opportunity to review and comment on how such changes would affect them and the care and services they provide. Third, the State did not publish the approved rate reduction and methodology changes in accordance with 42 C.F.R. § 447.205(d).

62. Rather, the "rate freeze" and Ill. Admin. Code §§ 153.125 & 153.126, as amended, became law without affording Plaintiffs its rights under 42 U.S.C. § 1396a(a)(13)(A), 42 C.F.R. § 447.205, and the state plan.

63. Thus, the State's failure to comply with the requirements of 42 U.S.C. § 1396a(a)(13)(A), 42 C.F.R. § 447.205, and the state plan renders the "rate freeze" and Ill. Admin. Code §§ 153.125 & 153.126, as amended, unenforceable and of no force and effect.

64. As a consequence of the foregoing acts, the Plaintiffs will be irreparably harmed.

COUNT VII - 42 U.S.C. §§ 1983 & 1988 – Declaratory and Injunctive Relief

65. Plaintiffs specifically incorporate and reallege the allegations asserted in each of the

preceding paragraphs, as if fully set forth herein.

66. Section 1983 of Title 42 of the United States Code provides that any person under color of state law who deprives a citizen of the United States of any federal rights, privilege, or immunity "shall be liable to the party injured in an action at law, suit in equity, or other proceeding for redress. . . " 42 U.S.C. § 1983.

67. Subpart (a)(13)(A) of Section 1396a of Title 42 of the United States Code provides that a State plan for medical assistance must provide:

> (A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—
>
> (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,
> (ii) providers, beneficiaries, and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,
> (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and
> (iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1396r-4 of this title) the situation of hospitals which serve a disproportionate number of low-income patients with special needs

42 U.S.C. § 1396a(a)(13)(A)

68. Subpart (a) of Section 447.250 of Title 42 of the Code of Federal Regulations, which implements 42 U.S.C. § 1396a(a)(13)(A), requires that the State of Illinois Medicaid plan "provide[s] for hospital and long-term care facility services through the use of rates that the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the

costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with State and Federal laws, regulations, and quality and safety standards." 42 C.F.R. § 447.205

69. Defendant, the Director, in her official capacity, is a person under 42 U.S.C. § 1983 for purposes of declaratory and injunctive relief.

70. The actions of HFS and the Director described in this Complaint have been taken under the color of State law.

71. Moreover, HFS and the Director have deprived Provider Plaintiffs of rights created by 42 U.S.C. § 1396a(a)(13)(A) by refusing and failing to provide a "public process" under which: (i) the proposed rates, methodologies and justifications behind HFS' proposed rate/change in rate; (ii) Provider Plaintiffs and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications behind HFS' proposed rate methodologies; (iii) the final rates, the methodologies underlying th establishment of such rates, and justifications for such final rates relating to the reimbursement rates for long-term care facilities are published.

72. Provider Plaintiffs are entitled to a declaration pursuant to 42 U.S.C. § 1983, that its civil rights have been violated by HFS and the Director by their refusal to reimburse Provider Plaintiffs for support costs in consideration of its cost-efficiency in its geographic region of the State of Illinois pursuant to 89 Ill. Admin Code section 140.561(a).

73. Provider Plaintiffs are entitled to a declaration pursuant to 42 U.S.C. § 1983, that its civil rights have been violated by HFS and the Director for their refusal to provide for a "public process" pursuant to 42 U.S.C. § 1396a(a)(13)(A), which, among other things, would require HFS and the Director to publish their methodologies and justifications supporting their proposed

reimbursement rate, and allow for Provider Plaintiffs and others a reasonable opportunity to review and comment on such information.

74. Provider Plaintiffs are entitled to a preliminary injunction, pursuant to 42 U.S.C. § 1983, requiring HFS and the Director, retroactive to…….. to establish the appropriate reimbursement rate(s) for Provider Plaintiffs consistent with the information provided by Provider Plaintiffs in its cost reports, or, in the alternative, based upon the cost report filed by the operator,

75. Provider Plaintiffs are entitled to a mandatory injunction, pursuant to 42 U.S.C. § 1983, requiring HFS and the Director, retroactive to April….., to establish the appropriate reimbursement rate for Provider Plaintiffs based upon its actual cost reports and in consideration of its cost-efficiency within its geographic area pursuant to 89 Ill. Admin. Code sec. 140.561(a).

76. Provider Plaintiffs are entitled to a mandatory injunction, pursuant to 42 U.S.C. § 1983, requiring HFS and the Director, retroactive to ….. date, to provide for a "public process" pursuant to 42 U.S.C. § 1396a(a)(13)(A), which, among other things, would require HFS and the Director to publish their methodologies and justifications supporting their reimbursement rate and allow for Provider Plaintiffs and others a reasonable opportunity to review and comment on such information.

77. As an incident of bringing and maintaining this action, Provider Plaintiffs have incurred and will incur litigation costs, and is entitled, pursuant to 42 U.S.C. § 1988, to an award of its reasonable attorneys' fees.

Requests for Relief

1. Declaring that Defendants, HFS, and the Director, have violated Provider Plaintiffs' rights under 42 U.S.C. § 1396a(a)(13)(A); 42 C.F.R. §§ 447.250(a), 447.205; and 42 U.S.C. § 1983;

2. Preliminarily and permanently enjoining HFS and the Director, and their agents, successors, and all persons acting in concert with them from implementing practices and procedures whereby Provider Plaintiffs are denied treatment in accordance with 42 U.S.C. § 1396a(a)(13)(A), 42 C.F.R. §§ 447.250(a), 447.205; and Ill. Admin. Code §§ 140.560 & 140.561;

3. Issuing a mandatory injunction requiring HFS and the Director, retroactive to …. To establish and process the appropriate reimbursement rate(s) for Provider Plaintiffs consistent with the information provided by Plaintiffs in its …. Cost report, in accordance with 89 Ill. Admin. Code 140.560(a);

4. Issuing a mandatory injunction requiring HFS and the Director to establish and process the appropriate reimbursement rate for Provider Plaintiffs based upon its actual cost and in consideration of its cost-efficiency within its geographic area pursuant to 89 Ill. Admin. Code 140.561(a);

5. Issuing a mandatory injunction requiring HFS and the Director, retroactive to …. To provide for a "public process" pursuant to 42 U.S.C. § 1396a(a)(13)(A), which, among other things would require HFS and the Director to publish their methodologies and justifications supporting their reimbursement rate for Provider Plaintiffs and allow for Provider Plaintiffs and others a reasonable opportunity to review and comment on such information;

6. Awarding Provider Plaintiffs reasonable attorneys' fees and costs pursuant to 42 U.S.C. § 1988; and

7. Granting such other and further relief as this Court deems appropriate under the circumstances.

Respectfully submitted,

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