No. 21-806

In the Supreme Court of the United States

HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY, ET AL., PETITIONERS

v.

GORGI TALEVSKI, BY HIS NEXT FRIEND IVANKA TALEVSKI

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR THE AMERICAN HEALTH CARE ASSOCIATION AND INDIANA HEALTH CARE ASSOCIATION AS AMICI CURIAE SUPPORTING PETITIONERS

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INTEREST OF AMICI CURIAE

The American Health Care Association (AHCA) serves as the national representative of more than 14,000 facilities dedicated to improving the lives of more than 1.5 million Americans who live in Medicare-participating skilled nursing facilities (SNFs), Medicaid-participating nursing facilities (NFs), assisted living communities, and other settings throughout the United States. One way in which AHCA promotes the interests of its members is by participating as an amicus curiae in cases such as this one, which presents important legal questions related to the federal statutory scheme governing SNFs/NFs' participation in the Medicare and Medicaid programs. Importantly, Congress enacted that statutory scheme using Spending Clause legislation: the Omnibus Budget Reconciliation Act of 1987 (OBRA), Pub. L. No. 100-203, §§ 4201(a)(3), 4211(a)(3), 101 Stat. 1330, 1330-160, 1330-182 (codified at 42 U.S.C. §§ 1395i-3, 1396r).[*]

The Indiana Health Care Association (InHCA) is a trade association whose members provide long-term care services and supports to more than 28,000 of Indiana's geriatric, developmentally disabled, and other citizens. InHCA is Indiana's largest trade association and advocate representing proprietary, not-for-profit,

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[*] No counsel for a party authored this brief in whole or in part, and no person other than the amici curiae, their members, or their counsel made a monetary contribution intended to fund the preparation or submission of this brief. Counsel of record for petitioners and respondent received notice of the amici's intent to file this brief more than ten days before the due date. Counsel of record for petitioners and respondent have provided written consent to the filing of this brief.

and hospital-based SNFs/NFs; assisted living communities; and independent living facilities. InHCA's more than 480 member-facilities provide over 10 million patient days of care per year. The majority of patients served by InHCA member-facilities are Medicare or Medicaid beneficiaries.

AHCA, InHCA, and their respective members have a substantial interest in the legal questions presented in this case. In reversing a district court's judgment to the contrary, the United States Court of Appeals for the Seventh Circuit held that certain Medicaid provisions enacted by OBRA create federal "rights" that can be privately enforced against NFs that are owned or operated by state or local governments, using damages suits under 42 U.S.C. § 1983. Pet. App. 3a; *see also* 42 U.S.C. § 1983 (providing that "[e]very person who, under color of any statute, ordinance, regulation, custom, or usage, of any State . . . subjects . . . any citizen of the United States or other person within the jurisdiction thereof to the deprivation of *any rights* . . . *secured by* the Constitution *and laws*, shall be liable to the party injured in an action at law") (emphasis added).

The petition for a writ of certiorari explains why this case provides an excellent vehicle for the Court to squarely decide an important federal question on which several Members of the Court have long expressed interest: namely, whether Spending Clause legislation can create "rights" that are privately enforceable under § 1983. Rather than burden the Court by regurgitating petitioners' arguments, the amici wish to emphasize additional reasons why the Court should grant plenary review.

SUMMARY OF ARGUMENT

I. The Seventh Circuit's judgment rests on a misunderstanding of congressional intent that, contrary to this Court's opinion in *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), fails to take into account the complete breadth of the statutory changes enacted by OBRA. That Spending Clause legislation made nearly identical changes to the Medicare and Medicaid Acts, applying the same standards regardless of whether the facility participating in those programs is a private actor (as most are) or a public actor. What OBRA did not do, however, was include an express private right of action in either the Medicare or Medicaid Acts. And courts have overwhelmingly (and correctly) held that OBRA's amendments to the Medicare and Medicaid Acts did not create an implied private right of action.

The net result of all of this is that following the Seventh Circuit's judgment, public actors that own or operate SNFs/NFs are subject to damages suits under 42 U.S.C. § 1983 and related claims for attorney's fees under 42 U.S.C. § 1988(b) based on alleged violations of OBRA. Meanwhile, similarly situated private actors are not subject to such damages litigation because OBRA's amendments to the Medicare and Medicaid Acts did not include an express or implied private right of action.

Had Congress truly intended such disparate treatment of similarly situated participants in two government programs—whereby public participants in both programs are subject to *greater* litigation risk than their private counterparts for allegedly violating the *same* participation requirements—surely Congress

would have said so using unambiguous statutory language given how anomalous such a scheme would be in our federalist system of government. Congress included no such language in OBRA. In the absence of such clear and unambiguous statutory language, the Court should not ascribe to Congress an illogical intent to single out public actors for disfavored treatment by subjecting them and only them to damages suits seeking millions of dollars for alleged violations of Medicare and Medicaid participation requirements.

II. Further percolation of the questions presented is both unwarranted and unwise. In reversing the district court's judgment and rejecting the conclusion reached by several other district judges, the Seventh Circuit followed the mistake made by a divided Third Circuit panel over a decade ago that has since been repeated by the Ninth Circuit. As several Members of this Court have explained, only this Court can provide the clarity needed by plaintiffs and defendants alike regarding the application of § 1983 in the context of Spending Clause statutes. Such clarity is especially necessary in the specific context at issue here, as public actors throughout the United States face a potential wave of costly and time-consuming § 1983 litigation resulting from the COVID-19 pandemic. The Court should take this opportunity to provide the necessary clarity in this case, where all the parties are already represented by capable counsel.

ARGUMENT

I. THE SEVENTH CIRCUIT'S JUDGMENT RESTS ON A MISUNDERSTANDING OF CONGRESSIONAL INTENT, THE NET RESULT OF WHICH IS THAT PUBLIC ACTORS ARE SINGLED OUT FOR DISFAVORED TREATMENT

This Court has emphasized that § 1983 "does not provide an avenue for relief every time a state actor violates a federal law." *Rancho Palos Verdes v. Abrams*, 544 U.S. 113, 119 (2005). Instead, the Court requires nothing "short of an unambiguously conferred right to support a cause of action brought under § 1983." *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002). "[W]here the text and structure of a statute provide no indication that Congress intends to create new individual rights," the Court has explained, "there is no basis for a private suit, whether under § 1983 or under an implied right of action." *Id.* at 286; *see also id.* at 291 (Breyer, J., concurring in judgment) ("The ultimate question, in respect to whether private individuals may bring a lawsuit to enforce a federal statute, through 42 U.S.C. § 1983 or otherwise, is a question of congressional intent.").

Even if a plaintiff demonstrates that a federal statute establishes a "right," such a showing creates "only a rebuttable presumption that the right is enforceable under § 1983." *Rancho Palos Verdes*, 544 U.S. at 120 (internal quotation marks and citation omitted). The defendant "may defeat this presumption by demonstrating that Congress did not intend that remedy for a newly created right." *Id.* "The crucial consideration is what Congress intended." *Id.* (internal quotation marks and citation omitted).

The Seventh Circuit here relied heavily on the use of the words "rights" and "right" as they appear in certain Medicaid Act provisions enacted by OBRA. *See* Pet. App. 9a–10a (citing 42 U.S.C. § 1396r(c)(1)(A), (2)). But as this Court explained long ago in rejecting similar reliance on Congress's use of the word "right," "[i]n expounding a statute, [the Court] must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy." *Pennhurst*, 451 U.S. at 18 (internal quotation marks and citation omitted). And an examination of the whole law at issue here demonstrates that Congress did not intend to disfavor state and local actors by subjecting them—but not their private-actor counterparts—to damages suits for violating Medicare and Medicaid conditions of participation.

A. Public Actors Make Up a Small Portion of Medicare and Medicaid Providers

Medicare, which is funded entirely by the Federal Government, "stands as the largest federal program after Social Security. It spends about $700 billion annually to provide health insurance for nearly 60 million aged or disabled Americans, nearly one fifth of the Nation's population." *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1808 (2019). Medicaid, in contrast, "is a federal program that subsidizes the States' provision of medical services to 'families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services.'" *Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 323 (2015) (quoting 42 U.S.C. § 1396-1). "Like other Spending Clause legislation, Medicaid offers the States a bargain: Congress provides federal funds in exchange for the

States' agreement to spend them in accordance with congressionally imposed conditions." *Id.*

Importantly, participation in the Medicare and Medicaid programs as a provider of services is open to both private actors (who make up the vast majority of providers) and units of state and local government. For example, according to statistics published by the Centers for Medicare & Medicaid Services (CMS), there are 15,560 Medicare-participating SNFs in the United States, only 1,007 of which—or just 7.1 percent—are owned by a governmental entity. *See* Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities, 86 Fed. Reg. 42,424, 42,520 (Aug. 4, 2021).

Private ownership predominates in other provider settings as well. *See, e.g.*, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System, 86 Fed. Reg. 44,774, 45,586 (Aug. 13, 2021) (reporting that of the 3,195 Medicare-participating acute care hospitals in the United States, only 486—or just 15.2 percent—are owned by a governmental entity); *id.* at 45,604 (reporting that of the 360 Medicare-participating long-term care hospitals in the United States, only 10—or just 2.8 percent—are owned by a governmental entity); Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, 86 Fed. Reg. 42,528, 42,602 (Aug. 4, 2021) (reporting that of the 4,995 Medicare-participating hospices in the United States, only 127—or just 2.5 percent—are owned by a governmental entity); Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year

2022, 86 Fed. Reg. 42,362, 42,417 (Aug. 4, 2021) (reporting that of the 1,114 Medicare-participating inpatient rehabilitation facilities in the United States, only 108—or just 9.7 percent—are owned by a governmental entity); Medicare Program; FY 2022 Inpatient Psychiatric Facilities Prospective Payment System, 86 Fed. Reg. 42,608, 42,674 (Aug. 4, 2021) (reporting that of the 1,534 Medicare-participating inpatient psychiatric facilities in the United States, only 319—or just 20.8 percent—are owned by a governmental entity).

Moreover, in the specific provider context at issue here, most facilities (including the facility in this case) participate in both Medicare and Medicaid. Such dual-participating facilities fall within the definition of a SNF *and* a NF, and serve both Medicare and Medicaid beneficiaries. *See, e.g.*, Ctrs. for Medicare & Medicaid Servs., *Nursing Facilities*, https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/nursing-facilities/index.html (last visited Dec. 30, 2021) (explaining that "[i]n many cases it is not necessary to transfer to another nursing home when payment source changes to Medicaid NF" because "[m]any nursing homes are also certified as a Medicare [SNF]").

B. No Evidence Exists That Congress Intended to Single Out Public Actors for Disfavored Treatment by Enacting OBRA

The statutory language that the Seventh Circuit found sufficiently rights-creating was added to the Medicaid Act by OBRA and is nearly identical to language OBRA added to the Medicare Act. The only difference between the two is that the Medicaid Act

language enacted by OBRA uses the term "nursing facility," while the Medicare Act language enacted by OBRA uses the term "skilled nursing facility." *Compare* OBRA § 4211(a)(3), 101 Stat. at 1330-188 to 1330-190 (codified at 42 U.S.C. § 1396r(c)(1)(A), (2)) (Medicaid), *with* OBRA § 4201(a)(3), 101 Stat. at 1330-165 to 1330-167 (codified at 42 U.S.C. § 1395i-3(c)(1)(A), (2)) (Medicare). Further reflective of the Medicare and Medicaid Acts' near-identical participation requirements in the provider context at issue here, CMS has implemented both Acts using a single set of regulations that apply equally to SNFs and NFs. *See* 42 C.F.R. pt. 483.

Although the Seventh Circuit noted the similarity of the Medicaid and Medicare Act language enacted by OBRA, the court of appeals gave that detail no particular attention and instead quickly focused its attention on the Medicaid Act language because respondent happens to be a Medicaid beneficiary. *See* Pet. App. 4a ("The two sections [referring to 42 U.S.C. §§ 1395i-3, 1396r] are identical, and so from this point we will cite only to section 1396r [the Medicaid provision]."). However, this Court's opinion in *Pennhurst* instructs that a court must "look to the provisions of the whole law," not just bits and pieces. 451 U.S. at 18. And a legal analysis of appropriate scope demonstrates that the Seventh Circuit erred in finding that OBRA's amendments to the Medicaid Act create federal "rights" that can be enforced via damages suits under § 1983.

Start with something on which everyone agrees: OBRA did not add an express private right of action to either the Medicare or Medicaid Acts. *See, e.g.*, *Grammer v. John J. Kane Reg'l Ctrs.-Glen Hazel*, 570 F.3d 520, 525 n.2 (3d Cir. 2009) ("Residents of nursing

homes cannot directly sue to enforce compliance with federal standards. The statutes at issue in this case do not expressly authorize private causes of action to enforce their provisions and the parties do not dispute this."), *cert. denied*, 559 U.S. 939 (2010) (No. 09-696).

Next, consider that courts have overwhelmingly (and correctly) held that OBRA's amendments to the Medicare and Medicaid Acts did not create an *implied* private right of action. *See, e.g.*, *Grammer*, 570 F.3d at 533 n.6 (Stafford, J., dissenting) (collecting cases and explaining that "[i]n the implied right of action context, federal courts have consistently held that no implied private right of action exists under the Medicaid Act [or] OBRA").

Therefore, a ruling that OBRA creates "rights" that are privately enforceable against public actors under § 1983 produces the anomalous result that public actors are subject to damages suits by Medicaid and Medicare beneficiaries (and claims for attorney's fees) stemming from alleged violations of Medicaid and Medicare conditions of participation, on the one hand, while similarly situated private actors—who make up the vast majority of the provider community—cannot be sued by such beneficiaries for identical violations because OBRA's amendments to the Medicare and Medicaid Acts did not include an express or implied private right of action. That result simply makes no sense in our federalist system of government. Nor would it make sense from the lay perspective of the Medicare or Medicaid beneficiary, since whether such an individual has an enforceable "right" depends solely on who happens to own the facility in question.

At a minimum, the Court should expect Congress to use clear and unambiguous statutory language condoning such an illogical legal regime if that is what Congress truly intends. As this Court explained in *Pennhurst*:

> Unlike legislation enacted under § 5 [of the Fourteenth Amendment], . . . legislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions. The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.' . . . . There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it. Accordingly, if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously. . . . By insisting that Congress speak with a clear voice, we enable the States to exercise their choice knowingly, cognizant of the consequences of their participation.

451 U.S. at 17. OBRA contains no such language.

II. FURTHER PERCOLATION IS UNWARRANTED AND UNWISE

The Seventh Circuit readily acknowledged that it was rejecting several contrary rulings issued by district judges within the circuit. *See* Pet. App. 3a ("This is a difficult area of law, no doubt, and we appreciate the careful attention that both this district court and several others within our circuit have given to this issue."). The Seventh Circuit nonetheless decided to side with published opinions issued by the Third and

Ninth Circuits. *See id.* (citing *Grammer*, 570 F.3d 520, and *Anderson v. Ghaly*, 930 F.3d 1066 (9th Cir. 2019)).

That there exists superficial uniformity at the circuit level is hardly surprising under the circumstances. *See, e.g.*, *Gee v. Planned Parenthood of Gulf Coast, Inc.*, 139 S. Ct. 408, 410 (2018) (Thomas, J., joined by Alito and Gorsuch, JJ., dissenting from denial of certiorari) (surveying the Court's § 1983 jurisprudence and concluding: "We created this confusion. We should clear it up."). And as the petition explains (at 17), there exists substantial doctrinal confusion in the circuits. *See, e.g.*, *N.Y. State Citizens' Coal. for Children v. Poole*, 922 F.3d 69, 94 (2d Cir. 2019) (Livingston, J., dissenting) (concluding that this Court's "more recent jurisprudence calls into question the vitality of" the three-factor test established in *Blessing v. Freestone*, 520 U.S. 329 (1997)).

Continued uncertainty in this area of federal law comes at a particularly inopportune time. Residents of SNFs/NFs have been disproportionately impacted by the ongoing COVID-19 pandemic. *See, e.g.*, Medicare and Medicaid Programs; COVID-19 Vaccine Requirements for Long-Term Care Facilities, 86 Fed. Reg. 26,306, 26,306 (May 13, 2021) ("Individuals residing in congregate settings, regardless of health or medical conditions, are at greater risk of acquiring infections, and many residents [of SNFs/NFs] face higher risk of severe illness due to age, disability, or underlying health conditions."). That, in turn, has resulted in increased personal-injury litigation by or on behalf of such residents, including litigation raising difficult questions under the Public Readiness and Emergency Preparedness Act (PREP Act). *See, e.g.*, *Estate of Maglioli v. Alliance HC Holdings LLC*, 16 F.4th 393,

403–11 (3d Cir. 2021) (declining to defer to PREP Act guidance issued by the Department of Health and Human Services, and finding PREP Act did not preempt legal claims against SNF/NFs). As state and local governments attempt to recover from the significant toll imposed by the pandemic, a wave of § 1983 litigation—in which plaintiffs and their counsel are incentivized to use § 1983 because of the fee-shifting regime established by § 1988(b)—is the last thing state and local governments need (not to mention the federal courts that will be called upon to adjudicate the majority of such suits). *See, e.g.*, *Beaty v. Delaware County*, No. 2:21-cv-01617, 2021 U.S. Dist. LEXIS 169553, at *6 (E.D. Pa. Aug. 5, 2021) (denying motion to dismiss § 1983 action brought against county-owned SNF/NF arising out of the facility's response to the pandemic, after the district court confirmed it was bound by the Third Circuit's decision in *Grammer* and could not reach a contrary conclusion even if the district court believed *Grammer* was wrongly decided).

Nor does continued legal uncertainty inure to the benefit of plaintiffs. In those circuits that have not yet addressed the questions presented, public actors that own or operate SNFs/NFs and find themselves named as defendants in § 1983 litigation have ample reason—including statements made in this Court's more recent decisions and statements made by individual Members of this Court—upon which to litigate such cases through discovery, trial, and appeal rather than settle. Accordingly, the time has come for the Court to resolve the important federal questions presented by the petition. This case in which all parties are already represented by capable counsel provides an excellent vehicle in which to do so.

CONCLUSION

For the foregoing reasons and those contained in the petition, the petition should be granted.

Respectfully submitted.

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