No. 21-806

In The Supreme Court of the United States

HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY, *ET AL.*,
Petitioners,

v.

IVANKA TALEVSKI, PERSONAL REPRESENTATIVE OF THE ESTATE OF GORGI TALEVSKI, DECEASED,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF OF TOBY S. EDELMAN AS *AMICUS CURIAE* IN SUPPORT OF THE RESPONDENT

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INTEREST OF THE AMICUS[1]

Toby S. Edelman is a senior policy attorney at the Center for Medicare Advocacy.[2] Ms. Edelman has been representing older people who live in long-term care facilities at the federal level since 1977. She has testified before Congress and served on federal task forces, technical expert panels, and working groups on nursing home survey and enforcement issues. She participated in the meeting on enforcement of the Institute of Medicine's Nursing Home Committee, worked closely with staff of the chief sponsors of the Federal Nursing Home Reform Act, and testified in support of the Reform Act at one of the three Congressional hearings on the bills, the House Ways and Means Committee, Subcommittee on Health, on June 1, 1987.

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[1] Pursuant to U.S. Sup. Ct. R. 37.3(a), amicus certifies that all parties have consented to the filing of this brief. Pursuant to U.S. Sup. Ct. R. 37.6, amicus certifies that no counsel for any party authored this brief in whole or in part, no party or party's counsel made a monetary contribution to fund its preparation or submission, and no person other than amicus or her counsel made such a monetary contribution.

[2] Ms. Edelman appears in her personal capacity. Her organizational affiliation is provided for identification purposes only.

Since 1977, Ms. Edelman has been involved in key litigation to protect and support the rights of nursing home residents. She participated in early litigation to enforce federal transfer and discharge protections guaranteed by federal Bill of Rights provisions (*Fuzie* v. *Manor Care*, 461 F. Supp. 689 (N.D. Ohio 1977)), co-wrote an *amicus* brief in litigation filed by nursing homes residents challenging the survey and enforcement system for nursing homes (*Smith* v. *Heckler*, 747 F.2d 583, 590 (10th Cir. 1984)), wrote *amicus* briefs in two Supreme Court cases addressing nursing home residents' rights (*O'Bannon* v. *Town Court Nursing Ctr.*, 447 U.S. 773 (1980), and *Blum* v. *Yaretsky,* 457 U.S. 991 (1982)), and wrote an *amicus* brief in litigation brought by a nursing facility challenging the nursing home survey and enforcement system (*Beverly Health & Rehab. Servs., Inc.* v. *Thompson*, 223 F. Supp. 2d 73 (D.D.C. 2002)). In addition, Ms. Edelman was the lead attorney on behalf of a statewide class of nursing home residents in a successful action that required California to implement the Federal Nursing Home Reform Act after the state had publicly announced that it would not do so (*Valdivia* v. *Cali. Dep't of Health Servs.*, No. S-90-1226EJG EM, 1991 WL 80896 (E.D. Cal. Feb. 25, 1991); No.S-90-1226EJG/PAN, 1992 WL 554299 (E.D. Calif. Aug. 11, 1992)). Many of these cases were filed under 42 U.S.C. § 1983.

I. INTRODUCTION

The modern-day nursing home industry began with the enactment of Medicare and Medicaid and their enormous infusion of federal reimbursement.[3] Quality of care scandals erupted quickly. The Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging investigated the nursing home industry through hearings and research and, beginning in November 1974, issued a series of reports under the title *Nursing Home Care in the United States: Failure in Public Policy*.[4] The Introductory Report described the nursing home industry as "the most troubled, and troublesome, component of our entire health care system," with "scandal and abuse" plaguing nursing homes nationwide.[5] The Committee estimated that "at least 50 percent of U.S. nursing

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[3] S. Special Comm. on Aging, 93rd Cong., 2d Sess. *Nursing Home Care in the United States: Failure in Public Policy*, Introductory Rep., at 1, 21, 24 (1974) (*Failure in Pub. Policy,* Introductory Rep.); (*id.* at 21, Table 1: expenditures for nursing home care increased 465% between 1960 and 1970), https://ia802704.us.archive.org/16/items/nursinghomecarei00unit/nursinghomecarei00unit.pdf.

[4] *Failure in Pub. Policy*, Introductory Rep.

[5] *Id.* at III (emphasis omitted).

homes are substandard with one or more life-threatening conditions."[6]

> In many cases, [residents] have not even received humane treatment. And in an alarming number of known cases, they have actually encountered abuse and physical danger, including unsanitary conditions, fire hazards, poor or unwholesome food, infections, adverse drug reactions, over tranquilization, and frequent medication errors. In addition, they have been exposed to negligence on the part of nursing home personnel. The net impact is that far too many patients have needlessly sustained injury and, in some cases, death.[7]

Failure in Public Policy documented multiple causes of poor resident care, including weak standards, inadequate staffing and lax or non-existent enforcement.[8]

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[6] *Id*. at XI.

[7] *Id.* at 1.

[8] See also Joshua M. Wiener et al., *Nursing Home Quality Twenty Years After The Omnibus Budget Reconciliation Act of 1987,* RTI International (Dec. 2007) https://www.kff.org/wp-content/uploads/2013/01/7717.pdf.

In the nearly 50 years since the Senate Aging Committee series was released, federal regulation of nursing homes has become more detailed and specific, with an increasing focus on identifying and meeting the health care and psychosocial needs of residents, guaranteeing residents' rights, and ensuring that residents' needs and rights are more fully met through an effective and comprehensive survey and enforcement system. These efforts culminated with the enactment of the federal Nursing Home Reform Act (FNHRA). The law established residents' rights as an enforceable standard for nursing facilities receiving Medicare or Medicaid reimbursement, or both, and strengthened federal standards of care (now called Requirements of Participation) and public survey and enforcement options while expressly preserving residents' rights to private enforcement through litigation brought pursuant to Section 1983. As part of its comprehensive set of enforcement methods, and adopting a House provision that includes "remedies available to residents at common law, including private rights of action to enforce compliance with requirements for nursing facilities,"[9] Congress explicitly enacted statutory language recognizing that "[t]he remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed

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[9] H. Rep. No. 391(I), 100th Cong., 1st Sess. at 472 (1987).

as limiting such other remedies, including any remedy available to an individual under common law."[10]

Despite the dramatic changes in federal law over the past 57 years, particularly enactment of FNHRA, nursing home residents too often are victimized by facilities that know they are unlikely to face enforcement actions or financial consequences for providing poor, even life-threatening, care.[11] The devastating toll of the COVID-19 pandemic on residents – more than twenty percent of the deaths nationwide have been residents,[12] although the 1.3 million residents make up 0.004 percent of the population of the United States, and residents in 2020

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[10] 42 U.S.C. §1396r(h)(8) (Medicaid). The Medicare law is substantively identical, 42 U.S.C. § 1395i-3(h)(5).

[11] T*he Nursing Home Reform Act Turns Twenty: What Has Been Accomplished, and What Challenges Remain?*: Hearing Before the S. Special Comm. on Aging, 110th Cong., 1st Sess. (2007), https://books.googleusercontent.com/books/content?req=AKW5QacdfgEs9jlJKGG_VJFKaFnN8hfzWzgEt_uPtmhdvPf2g18hbfDyPlQh4JffKqNGxZO-0MAbQ306No0bmvWhDkPgUA67VaKzO-JDfsGJ4EwlwG2laL5d4d6_EKZ9PQm40qoJXBbEcZb5mVoboPOOdQES83j-t38JE7SgGpePvYlAC5y5aID-NhPBl7OQK7dcifl4A61l8WDMPsxF3vhDFdeqVQnWVGFBrU6B0JOkt1EhgXb0a7VMKdCiB5Yv67FpLkht3F8nFva2dkoL1Uoy6O_ajzqLCA.

[12] Priya Chidambaram, *A Look at Nursing Facility Characteristics Through July 2022,* Kaiser Family Foundation (Aug. 24, 2022), https://www.kff.org/medicaid/issue-brief/a-look-at-nursing-facility-characteristics-through-july-2022/.

declined in seven of eight key indicators of mental and physical health reviewed by the Government Accountability Office[13] – has highlighted the substandard conditions today in far too many nursing facilities.

II. SUMMARY OF THE ARGUMENT

Congress has been concerned for decades with the poor quality of care provided by nursing facilities receiving public funding from the Medicare and Medicaid programs. It has also expressed repeated concern with the need for residents' rights to be firmly established in law and protected and for the oversight and enforcement system to be comprehensive and effective. FNHRA addressed these longstanding issues. The regulatory and legislative history of FNHRA demonstrates that Congress expressly intended to allow private actions by residents as a critical tool in the comprehensive enforcement scheme.

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[13] GAO, *COVID-19 in Nursing Homes: CMS Needs to Continue to Strengthen Oversight of Infection Prevention and Control*, GAO-22-105133, at 10 (Sep. 2022), https://www.gao.gov/assets/gao-22-105133.pdf.

III. ARGUMENT

A. Legislative and Regulatory History of the Federal Nursing Home Reform Act Demonstrates Increasing Efforts to Protect Residents' Rights, Including by Private Enforcement

1. Early Efforts to Address Standards of Care: Insufficient Enforcement Authority

The Medicare and Medicaid programs have paid for nursing home care since their enactment in 1965. Medicare paid for post-hospital skilled care in what federal law called "extended care facilities." Medicaid also paid for skilled care in skilled nursing facilities.[14]

The decade of the 1970s saw efforts to define federal standards of care for the two categories of nursing homes – Skilled Nursing Facilities (SNFs) and intermediate care facilities – and the two payment programs – Medicare and Medicaid. However, as the Senate Special Committee on Aging reported in 1974:

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[14] Comm. on Nursing Home Regul., Institute of Med., *History of Federal Nursing Home Regulation*, *in* IMPROVING THE QUALITY OF CARE IN NURSING HOMES, National Academies Press, at 241-242 (Mar. 1986), https://www.ncbi.nlm.nih.gov/books/NBK217552/ (IoM, *Improving the Quality of Care in Nursing Homes*).

> There is no direct Federal enforcement of these (regulations) and previous Federal standards. Enforcement is left almost entirely to the States. A few do a good job, but most do not. In fact, the enforcement system has been characterized as scandalous, ineffective, and, in some cases, almost nonexistent.[15]

The Committee concluded: "For the most part, these programs do not develop or manage long-term care resources; they merely pay for services provided by proprietary and nonprofit long-term care institutions."[16] In short, in the early years of the Medicare and Medicaid programs, setting and enforcing federal standards of care were limited as the federal government assumed a "lenient regulatory policy."[17] Changes in federal standards and oversight of nursing homes occurred, but slowly and with limited effectiveness.

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[15] *Failure in Public Policy,* Supporting Paper No. 1, *The Litany of Nursing Home Abuses and an Examination of the Roots of Controversy XI* (Comm. Print 1974), at XII.

[16] *Failure in Pub. Policy,* Introductory Rep., at 29.

[17] Catherine Hawes et al., *The Changing Structure of the Nursing Home Industry and the Impact of Ownership on Quality, Cost, and Access*, *in* FOR-PROFIT ENTERPRISE IN HEALTH CARE, National Academy of Sciences, a 492-(Bradford H. Gray ed., 1986), https://www.ncbi.nlm.nih.gov/books/NBK217907/.

Initial Congressional efforts focused on curbing costs. When actual Medicare program costs far exceeded initial cost expectations in the early days of the Medicare program, a key Congressional goal became "cutting costs."[18] Accordingly, when facilities could not meet Medicare standards of care, Congress created a new, less intensive and less expensive level of care under Medicaid in 1971 – called intermediate care facilities[19] – and directed the Secretary to establish limited federal standards addressing only "safety and sanitation."[20]

The Social Security Amendments of 1972 required uniform standards for skilled nursing facilities under both Medicare and Medicaid,[21] but reduced care standards by authorizing the waiver of registered

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[18] *Failure in Pub. Policy,* Introductory Rep., at 29, 39.

[19] Pub. L. No. 92-223, sec. 4, 85 Stat. 802, 809, amending § 1905(a) of the Social Security Act of 1935, Pub L. 74-241, 49 Stat. 620 (codified as amended at 42 U.S.C. §§ 301-1397) (Social Security Act); created the intermediate (ICF) level of care under Medicaid, 42 U.S.C. 1396d, https://www.congress.gov/92/statute/STATUTE-85/STATUTE-85-Pg802.pdf. See *Failure in Pub. Policy,* Introductory Rep., at 38.

[20] 42 U.S.C. § 1396d(C)(3).

[21] Pub. L. 92-603, sec. 246, 86 Stat. 1329, 1424, amending § 1902(a)(28) of the Social Security Act.

nurse coverage on weekends in rural facilities[22] and eliminating the requirement for medical social workers.[23] The 1972 Amendments also created an enforcement remedy, authorizing the Secretary of the Department of Health, Education, and Welfare (HEW) to terminate health care providers, including nursing facilities, for, among other reasons, providing services "of a grossly inferior quality."[24] This limited enforcement remedy remained the only federal remedy available until a 1980 amendment, which, as discussed below, was not implemented by federal regulations until 1986.

Final rules for skilled nursing facilities, applicable to both Medicare and Medicaid, published January 17, 1974,[25] noted that commenters on the proposed rules recommended a "bill of rights" for patients.[26] However, since the proposed rules had not included a

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[22] Pub. L. 92-603, sec. 267, 86 Stat. 1329, 1450, amending §1861(j) of the Social Security Act.

[23] Pub. L. 92-603, sec. 265, 86 Stat. 1329, 1450, amending §1861(j)(11) of the Social Security Act, as redesignated sec. 234(d).

[24] Pub. L. 92-603, sec. 229, 86 Stat. 1329, 1408-10, amending §1862(d)(1)(B) of the Social Security Act.

[25] 39 Fed. Reg. 2238 (Jan. 17, 1974), https://archives.federalregister.gov/issue_slice/1974/1/17/2188-2231.pdf#page=33.

[26] *Id*.

bill of rights, HEW would issue proposed rules for a bill of rights at a future time. The final rules created 18 Conditions of Participation for SNFs, each with subsections identified as Standards that addressed physician services, nursing services, social services, activities, medical records, and infection control, among other requirements.[27] The final rules also addressed "Standards for payment" for SNFs and ICFs that mandated surveys by state survey agencies and permitted certification of facilities with deficiencies if they submitted plans of correction that were acceptable to the state agency. [28]

Residents' rights in intermediate care facilities were proposed on March 4, 1975[29] to parallel the rights afforded to residents of skilled nursing facilities and were made final on March 29, 1976.[30] The standard on residents' rights, 45 C.F.R. § 249.12, addressed admission, transfer and discharge policies; policies on chemical and physical restraints; informing residents of their rights and

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[27] 45 C.F.R. §§ 405.1101, .1120-.1137.

[28] 45 C.F.R. § 405.1908(a)(1).

[29] 40 Fed. Reg. 8956 (Mar. 4, 1975), https://www.govinfo.gov/content/pkg/FR-1975-03-04/pdf/FR-1975-03-04.pdf.

[30] 41 Fed. Reg. 12,883 (Mar. 29, 1976), https://archives.federalregister.gov/issue_slice/1976/3/29/12878-12885.pdf#page=6.

responsibilities; confidential treatment of residents' records; and more.

While federal regulations included a residents' bill of rights for skilled nursing and intermediate care facilities by the mid-1970s, the federal oversight system imposed remedies only for violations of certain federal standards of care and enforcement was limited to termination of federal funding.

First, the federal regulations distinguished "Conditions of Participation," which were based on statutory requirements, from sub-Condition "Standards," which were based on regulatory requirements. In final rules setting care standards for nursing homes, published in February 1989, the Health Care Financing Administration (HCFA, the federal agency with responsibility for the Medicare and Medicaid programs, now known as the Centers for Medicare & Medicaid Services, CMS) explained how federal enforcement policy operated:

> The condition of participation (COP) format traditionally used by Medicare and Medicaid consists of condition level statements. It has been based on the principle that each condition level statement would be a statutory requirement while standard level statements would be lesser requirements. A facility could be found

> to have deficiencies at the standard level and be making efforts to correct them while it continued to participate in the Medicare program but was subject to termination if it failed to meet a condition level (i.e., statutory) requirement. Regardless of the significance of the requirement, that is, whether the requirement was a COP or a standard within a condition, the facility was responsible for fully complying with all requirements.[31]

Simply stated, the federal government could impose a sanction only when a facility violated a Condition of Participation; it did not sanction violations of regulatory requirements that were called Standards, such as residents' rights.

It was not until final rules were published in 1989 that HCFA firmly erased the distinctions between Conditions and Standards, renaming as "Requirements" all of the regulatory standards of care for nursing homes. HCFA's express purpose was correcting a "misunderstanding that violations of the

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[31] HCFA, "Medicare and Medicaid. Requirements of Participation for long-Term Care Facilities; Final Rule with Request for Comments," 54 Fed. Reg. 5316, 5317 (Feb. 2, 1989), https://archives.federalregister.gov/issue_slice/1989/2/2/5300-5363.pdf#page=60.

'lesser' requirements would not be subject to Federal enforcement."[32]

Second, the only enforcement remedy available to the federal government was complete termination from a federal payment program, a drastic remedy that was seen as harming residents[33] and rarely used.[34] In 1980, Congress authorized a new remedy, denial of payment for new admissions, but the sanction could not be imposed until a facility had "a reasonable opportunity . . . to correct its deficiencies, and, following this period, [had] been given reasonable notice and opportunity for hearing."[35] Implementation of this limited sanction was further delayed. The

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[32] *Id.*

[33] S. Special Comm. on Aging, 99th Cong., 2d Sess., *Nursing Home Care: the Unfinished Agenda*, Serial No. 99-J, at 11 (May 21, 1986), https://books.google.com/books?id=VgL98RU0lC4C&printsec=frontcover&source=gbs_book_other_versions_r&cad=4#v=onepage&q&f=false.

[34] In November 1987, HCFA reported that there were 15,100 certified nursing facilities and that only 124 had been involuntarily terminated between Calendar Years 1983 and 1985, 0. 8%. 52 Fed. Reg. 44,300, 44,305 (Nov. 18, 1987), https://www.govinfo.gov/content/pkg/FR-1987-11-18/pdf/FR-1987-11-18.pdf.

[35] 42 U.S.C. § 1396a(i)(2), enacted in Pub. L. No. 99-499, Omnibus Budget Reconciliation Act of 1980, § 916(b).

Department published proposed rules in 1985[36] and final rules in 1986.[37] The Institute of Medicine described the new sanction, which was repealed by FNHRA,[38] as "more difficult and slower to implement than decertification"[39] when the sanction could not be imposed until after a formal hearing.

The result of the policy limiting enforcement to Conditions of Participation and of the single available sanction for noncompliance was tolerance of grossly substandard care, including violations of residents' rights.

As documented by both the Senate Special Committee on Aging in its *Failure in Public Policy* series,[40] and by the Institute of Medicine in its 1986 report *Improving the Quality of Care in Nursing Homes*,[41] Congress was highly critical of both the regulatory standards and the survey and enforcement system, which allowed facilities with serious

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[36] 50 Fed. Reg. 7191 (Feb. 21, 1985).

[37] 51 Fed. Reg. 24,484 (Jul. 3, 1986).

[38] Pub. L. No. 100-203, sec. 4213(b), 101 Stat. 1330.

[39] IoM, *Improving the Quality of Care in Nursing Homes*, at 159.

[40] *Failure in Pub. Policy,* Introductory Rep., at 1, 21, 24.

[41] IoM, *Improving the Quality of Care in Nursing Homes*, Appendix A, History of Federal Nursing Home Regulation, at 243.

deficiencies to continue receiving reimbursement from the Medicare and Medicaid programs.

New efforts to strengthen federal standards of care began on June 8, 1978, when HCFA announced three-day public hearings in each of five cities between June and August 1978 "to discuss new directions on standards for, and survey and certification of, skilled nursing facilities (SNF's) and intermediate care facilities (ICF's)."[42] The announcement was called "New Directions for Skilled Nursing and Intermediate Care Facilities."

2. The Regulatory Battle over Residents' Rights

Proposed revisions to the Conditions of Participation for Skilled Nursing and Intermediate Care Facilities for facilities participating in Medicare and Medicaid, published July 14, 1980, began with a discussion of comments received in the 15 days of public hearings held in 1978.[43] HCFA wrote, "Many commenters urged broader concern for patients' rights—not just legal rights, but the right to self-

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[42] 43 Fed. Reg. 24,873 (Jun. 8, 1978), https://www.govinfo.gov/content/pkg/FR-1978-06-08/pdf/FR-1978-06-08.pdf.

[43] 45 Fed. Reg. 47,368, 47,368-85 (July 14, 1980), https://www.govinfo.gov/content/pkg/FR-1980-07-14/pdf/FR-1980-07-14.pdf.

determination and involvement in planning the services and activities which will characterize the patient's life for an extended period of time."[44]

Responding to the public comments, HCFA described, as its first "innovation" in the July 14, 1980 Notice of Proposed Rulemaking, elevation of Patients' rights to a Condition of Participation.[45] HCFA explained its rationale:

> There are significant innovations in this rule, however, which we hope will serve as models for State nursing home regulations. First, we have elevated Patients' Rights to the level of a Condition of Participation. This expanded section testifies to the Department's position that one does not surrender the right to self-determination when entering a long-term care facility. The standards in this Condition reinforce the specifics of this concept and will become items to be evaluated during the survey process. Review of the literature and existing State laws on patients' rights suggests that by developing Standards which comprise a

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[44] *Id*. at 47,368.

[45] *Id*.

> Condition, the Department will strengthen the enforcement capability for Patients' Rights. Clearly, we do not pretend to provide "new" rights to nursing home patients; constitutional and legal rights are guaranteed by other more prestigious means than this regulation. Rather, we intend to reaffirm the position that institutionalization in a nursing home does not constitute an abrogation of these rights and, further, we set in place a mechanism to assure this, by incorporating a more definitive structure for patients' rights in the survey process through establishing it as a Condition of Participation.[46]

The Carter Administration was unable to issue final regulations revising the Conditions of Participation before the end of its term. On January 19, 1981, outgoing Secretary of the Department of Health and Human Services Patricia Roberts Harris addressed a single proposal included in the 1980

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[46] *Id*. at 47,369.

proposed rules, signing final regulations to elevate residents' rights to a Condition of Participation.[47]

Two days later, on January 21, 1981, Acting Health and Humans Services Secretary Donald S. Frederickson rescinded the Carter Administration's residents' rights Condition of Participation.[48] A notice published in the Federal Register on January 23, 1981 explained the Reagan Administration's reasons for the rescission.[49]

The Administration then began a process of deregulating nursing homes.[50] A draft version of the Conditions of Participation, which omitted residents' rights entirely from federal regulatory requirements and made other significant changes, became public in early 1982. Opposition to the draft regulations from consumer groups, state regulators, Congress, and others led Secretary Richard Schweiker to issue a

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[47] IoM, *Improving the Quality of Care in Nursing Home*s, Appendix A, History of Federal Nursing Home Regulation, at 248.

[48] IoM, *Improving the Quality of Care in Nursing Homes*, at 15.

[49] 46 Fed. Reg. 7406 (Jan. 23, 1981), https://www.govinfo.gov/content/pkg/FR-1981-01-23/pdf/FR-1981-01-23.pdf.

[50] IoM, *Improving the Quality of Care in Nursing Homes*, Appendix A, History of Federal Nursing Home Regulation, at 248.

press release on March 21, 1982, in which he said, "'I will not imperil senior citizens in nursing homes by removing Federal protection. I will not turn back the clock.'"[51]

As the Institute of Medicine later described the Administration's actions, "finding it impossible to change the standards, the HCFA turned to an attempt to change the procedures for applying the standards"[52] – the survey and certification rules.

In May 1982, the Administration published proposed regulations, the Subpart S regulations, to permit less-than-annual surveys, self-surveys, and, most significantly, "deemed" status, meaning that facilities could avoid a public survey entirely if they were accredited by a private accrediting organization.[53]

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[51] *Nursing Home Survey and Certification: Assuring Quality Care*, Hearing Before S. Special Comm. On Aging, 97th Cong., 2nd Sess. (Jul. 15, 1982) at 2, https://www.aging.senate.gov/imo/media/doc/publications/7151982.pdf.

[52] IoM, *Improving the Quality of Care in Nursing Homes*, Appendix A, History of Federal Nursing Home Regulation, at 248.

[53] 47 Fed. Reg. 23,403 (May 27, 1982), https://www.govinfo.gov/content/pkg/FR-1982-05-27/pdf/FR-1982-05-27.pdf.

Congressional opposition to the deregulatory proposals in Subpart S was swift and bipartisan. The Chair and Ranking Member of the Senate Special Committee on Aging opposed the Subpart S proposals, as did 46 Members of the House (35 Democrats, 11 Republicans).[54] A resolution joined by 22 Members of Congress called for the proposed Subpart S rules to be rejected. In August 1982, all 15 members of the Senate Special Committee on Aging urged the Administration to withdraw the proposed Subpart S regulations and the chairs of all four House panels with jurisdiction over health care legislation introduced legislation to impose a moratorium on deregulation of nursing homes.[55]

Congress enacted two legislative moratoria that prevented a rollback of federal nursing home regulations. The Tax Equity and Fiscal Responsibility Act of 1982, enacted September 3, 1982, mandated a "[s]ix-month moratorium on deregulation of skilled nursing and intermediate care facilities" and

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[54] Robert Pear, *Nursing Home Plan Draws Opposition*, N.Y. Times (Jun. 13, 1982), https://www.nytimes.com/1982/06/13/us/nursing-home-plan-draws-opposition.html?searchResultPosition=9.

[55] Robert Pear, *Senate Aging Panel Attacks Plan to Ease Nursing Home Rules*, N.Y. Times (Aug. 5, 1982), https://www.nytimes.com/1982/08/05/us/senate-aging-panel-attacks-plan-to-ease-nursing-home-rules.html?searchResultPosition=14.

specifically prohibited any changes to conditions of participation for Medicare skilled nursing facilities, survey and certification procedures (Subpart S), and certification of skilled nursing facilities and intermediate care facilities under Medicaid.[56] A second moratorium was included in the continuing budget resolution enacted late in 1982. As a third moratorium was under discussion, Congress and the Administration reached a compromise: the Administration could not make any changes in federal nursing home regulations until the Institute of Medicine at the National Academy of Sciences undertook and released a study.[57] The study was begun in 1983[58] and completed in March 1986.

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[56] Pub. L. No. 97-248, sec. 135, 96 Stat. 324, 325 https://www,.congress.gov/97/statute/STATUTE-96/STATUTE-96-Pg324.pdf.

[57] IoM, *Improving the Quality of Care in Nursing Homes*, at 2; *Nursing Home Care: The Unfinished Agenda* (Vol. I): Hearing Before the S. Special Comm. on Aging, 99th Cong., 2d Sess., Serial No. 99-199, S. Hr'g. 99-1082, at 6 (May 21, 1986), https://www.aging.senate.gov/imo/media/doc/publications/5211986.pdf.

[58] *Nursing Home Care: The Unfinished Agenda* (Vol. I): Hearing Before the S. Special Comm. on Aging, 99th Cong., 2d Sess., Serial No. 99-199, S. Hr'g. 99-1082, at 6 (May 21, 1986), https://www.aging.senate.gov/imo/media/doc/publications/5211986.pdf.

3. The Institute of Medicine's Report and Recommendations: A Clear Appeal to Congress to Protect Residents' Individual Rights

The Nursing Home Committee of the Institute of Medicine (IoM) issued its comprehensive report, *Improving the Quality of Care in Nursing Homes*, in March 1986. Like the *Failure in Public Policy* series issued by the Senate Special Committee on Aging more than a decade earlier, the IoM described the "broad consensus that government regulation of nursing homes, as it now functions, is not satisfactory because it allows too many marginal or substandard nursing homes to continue in operation."[59] The IoM's detailed and specific recommendations are a key part of the legislative history of the FNHRA and were enacted 21 months later, generally as recommended, in the FNHRA.

IoM rejected a market-based approach to improving quality of care, noting, "[n]ursing homes were essentially unregulated in most states prior to the late 1960s. Their operations were governed almost entirely by market forces, and the quality of care was appalling."[60] IoM called for a strong regulatory system, identifying "two broad goals" for

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[59] IoM, *Improving the Quality of Care in Nursing Homes*, at 2.

[60] *Id.* at 5.

government regulation of nursing homes: "(1) consumer protection, that is, to ensure the safety of residents, the adequacy of care they receive, and that their legal rights are protected; and (2) to control and account for the large public expenditures – mainly Medicaid – used to pay for nursing home care."[61] FNHRA enacted these identical goals as the "general duty and responsibility" of the federal government in the regulation of nursing homes:

> It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in nursing facilities under State plans approved under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.[62]

IoM also made specific and detailed recommendations across three broad areas: the standards of care that facilities must meet to be eligible for Medicare or Medicaid reimbursement, or

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[61] *Id.* at 12.

[62] See 42 U.S.C. § 1396r(f)(1) (Medicaid). The Medicare provision is substantively identical. 42 U.S.C. § 1395i-3(f)(1).

both;[63] the survey process for determining compliance with those standards;[64] and the enforcement system for imposing remedies against facilities not meeting care standards.[65] All of these recommendations were enacted in FNHRA.[66]

Two months after the IoM issued its report, the Senate Special Committee on Aging held a hearing, "Nursing Home Care: The Unfinished Agenda," that reiterated concerns about the poor quality of care in many nursing homes.[67] A staff report, with the same name and release date as the hearing, concluded, after a two-year investigation, that "our current systems of inspection and enforcement are incapable of assuring that residents actually receive the high quality care the law demands."[68] The staff report concluded that

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[63] IoM, *Improving the Quality of Nursing Home* Care, at 69-103.

[64] *Id.* at 104-145.

[65] *Id.* at 146-170.

[66] 42 U.S.C. §§ 1395i-3(a)-(h), 1396r(a)-(h).

[67] *Nursing Home Care: The Unfinished Agenda* (Vol. I): Hearing Before S. Special Comm. on Aging, 99th Cong., 2d Sess., Serial No. 99-199, S. Hr'g. 99-1082, (May 21, 1986), https://www.aging.senate.gov/imo/media/doc/publications/5211986.pdf.

[68] S. Special Comm. on Aging, 99th Cong., 2d Sess., *Nursing Home Care: the Unfinished Agenda*, Serial No. 99-J, at iii (May 21, 1986),

"Congress must act to effectively strengthen these systems and underscore the rights of patients to appropriate, quality care."[69]

4. Enactment of FNHRA: Protection of Private Enforcement Via the Construction Clause

Members of Congress introduced bills to implement the IoM Committee's detailed and comprehensive recommendations.[70] These bills included two House bills: H.R. 2270, Medicaid Nursing Home Quality Care Amendments of 1987, introduced May 5, 1987, revising the Medicaid law, and H.R. 2770, Medicare Nursing Home Quality Care Amendments of 1987, introduced June 24, 1987, revising the Medicare law, and a Senate bill, S. 1108, introduced April 29, 1987, revising both Medicare and Medicaid. These bills were the subject of Congressional hearings in the three Committees with legislative authority over the Medicare and Medicaid programs.

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https://books.google.com/books?id=VgL98RU0lC4C&printsec=frontcover&source=gbs_book_other_versions_r&cad=4#v=onepage&q&f=false.

[69] *Id.*

[70] 133 Cong. Rec., May 5, 1987, at 11263 (H.R. 2270 is based on recommendations of the Institute of Medicine).

On October 26, 1987, the two House bills were consolidated into a single House bill, H.R. 3545. Section 4114, amending the Medicaid portion of the Reform law, set out a series of alternative remedies that states and the Secretary could impose or would be required to impose under certain circumstances. The House report for H.R. 3545 described the need to improve enforcement of federal standards of care for residents:

> Based on a review of enforcement case files for 26 nursing homes in 5 States, the GAO[71] found that, under current law, "nursing homes that have serious deficiencies…those that jeopardize patient health and safety or seriously limit the facility's ability to provide adequate care…are able to remain in the Medicare or Medicaid program without incurring any penalty if the deficiencies are adequately corrected before the expiration of the certification period or before the effective date of termination action. In other words, nursing homes know in advance that they will not be penalized if caught with serious

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[71] GAO, *Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed*, GAO/HRD-87-113 (Jul. 1987), https://www.gao.gov/assets/hrd-87-113.pdf.

> deficiencies as long as they correct them sufficiently to qualify for recertification or stop ongoing decertification action." The GAO also found that, "when deficiencies do not seriously threaten patient health or safety, there are no effective Federal sanctions to deter noncompliance. Even if the facility is repeatedly out of compliance, it will incur no penalty for not maintaining compliance."[72]

The House report recognized that improved standards of care, by themselves, would not be sufficient to "bring the intended improvements in the quality of care for nursing facility residents."[73]

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[72] Comm. on Energy and Com., Subcommittee on Health and the Environment, *Report on Medicare and Medicaid Health Budget Reconciliation Amendments of 1987*, 100th Cong. 1st Sess. (Nov. 1987), Comm. Print 100-P, at 96-97, https://books.google.com/books?id=xzaQyHkbGeEC&newbks=1&newbks_redir=0&dq=%22The%20Committee%20emphasizes%20that%20the%20remedies%20specified%20under%20the%20amendment%20are%20not%20exclusive%2C%20and%20should%20not%20%22&pg=PA97&ci=29%2C522%2C943%2C340&source=bookclip#v=onepage&q=%22The%20Committee%20emphasizes%20that%20the%20remedies%20specified%20under%20the%20amendment%20are%20not%20exclusive%2C%20and%20should%20not%20%22&f=false.

[73] *Id.* at 97.

> Accordingly, the Committee amendment would specify a broad range of sanctions for use by both the Secretary and the States. The Committee expects that these sanctions will be invoked by both the Secretary and the States whenever necessary to promote compliance with the requirements of participation and assure high quality care for nursing facility residents. (The requirements of participation are those relating to the provision of services, residents' rights, preadmission screening, and administration and other matters.)[74]

The Committee further explained that public enforcement remedies of FNHRA were not the exclusive enforcement mechanism:

> The Committee emphasizes that the remedies specified under the amendment are not exclusive and should not be construed to limit the use of other remedies that may be available to either the States or the Secretary under State or Federal law. Nor should the specified remedies be construed to limit remedies available to residents at common law,

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[74] *Id.*

> including private rights of action to enforce compliance with requirements for nursing facilities.[75]

The legislative language used in both original House bills (H.R. 2270 and 2770) and in the consolidated bill, H.R. 3545, to confirm residents' private rights of action was the Construction Clause (or Savings Clause), now codified in FNHRA:

> The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law.[76]

The Senate bill had taken a different approach to enforcement. S. 1108 set out a requirement that states and the federal government have a process for determining penalties, with more severe sanctions imposed for more serious noncompliance, repeated noncompliance, and failure to correct deficiencies.

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[75] *Id.*

[76] 42 U.S.C. § 1396r(h)(8) (Medicaid). The Medicare provision is substantively identical. 42 U.S.C. § 1395i-3(h)(5).

Conferees agreed to include the House's detailed listing of remedies, the House Construction (or Savings) Clause, and the Senate process language – in short, all of the enforcement language proposed in the House and Senate bills – explaining, "The conference agreement includes both House provisions with an amendment incorporating Senate provisions."[77]

On December 22, 1987, Congress enacted FNHRA as part of the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, §§ 4201 (Medicare), 4211 (Medicaid).

The structure and detailed requirements of FNHRA are telling. Closely tracking the detailed recommendations of the IoM report, FNHRA has three major components: standards of care for facilities (with largely identical standards for Medicare and Medicaid), the survey process, and enforcement. The standards of care, now called Requirements, include three components: provision of

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[77] H. Conf. Rep. No. 100-495., at 724 (Dec. 21, 1987); 4 *U.S. Code Cong. & Ad. News*, 2313-1412, 100th Cong., 1st Sess. (1987) at 2313-1470.

services,[78] residents' rights,[79] and administration and other matters.[80]

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[78] Provision of services includes quality of life, scope of services and activities under plan of care, residents' assessment, provision of services and activities, required training of nurse aides, physician supervision and clinical records, required social services, and information on nurse staffing. 42 U.S.C. § 1396r(b)(1)-(8) (Medicaid). Medicare requirements are similar, 42 U.S.C. §§ 1395i-3(b)(1)-(8).

[79] Residents' rights include (A)(1) general rights (specified rights, including free choice, free from restraints, privacy, confidentiality, accommodation of needs, grievances, participation in resident and family groups, participation in other activities, examination of survey results, refusal of certain transfers), (B) notice of rights, (C) rights of incompetent residents, (D) use of psychopharmacologic drugs; (A)(2) transfer and discharge rights; (A)(3) access and visitation rights, (A)(4) equal access to quality care, (A)(5) admissions policy; (A)(6) protection of resident funds. 42 U.S.C. §§ 1396r(c)(A)(1)-(6) (Medicaid). Medicare rules are similar, 42 U.S.C. §§ 1395i-3(c)(A)(1)-(6).

[80] Administration and other matters include (1) administration; (2) Licensing and Life Safety Code; (3) sanitary and infection control and physical environment; (4) miscellaneous. 42 U.S.C. §§ 1396r(d)(1)-(4) (Medicaid). Medicare rules are similar, 42 U.S.C. §§ 1395i-3(d).

The Secretary's "duty and responsibility" are expanded beyond "health and safety" to include, for the first time, residents' "welfare and rights."[81]

The enforcement provisions include (from the House bill) a list of specified intermediate sanctions,[82] (from the Senate bill) language about identifying criteria for imposing sanctions, including imposing "incrementally more severe fines for repeated or uncorrected deficiencies,"[83] and (from the House bill), the Construction (or Savings) Clause:

> The remedies provided under this subsection are in addition to those otherwise available under State or federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law.[84]

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[81] 42 U.S.C. § 1396r(f)(1) (Medicaid). Medicare rules are identical. 42 U.S.C. §§ 1395i-3(f)(1). Prior to FNHRA, case law and federal statutory language were limited to enforcement of requirements related to resident health and safety.

[82] 42 U.S.C. §§ 1396r(h)(2)(A)(i)-(iv) (states), (h)(3)(C)(i)-(iii) (Secretary) (Medicaid), 1395i-3(h)(2)(B)(i)-(iii) (Medicare).

[83] 42 U.S.C. §§ 1396r(h)(2)(A) (Medicaid), 1395i-3(h)(2)(B) (Medicare).

[84] 42 U.S.C. § 1396r(h)(8) (Medicaid). The Medicare provision is substantively identical. 42 U.S.C. § 1395i-3(h)(5).

B. Congress Intended for FNHRA to Be Privately Enforceable by Residents. Enforcement of "Bill of Rights" Provisions Remains Critical

As documented, nursing home care in the United States has had a long history of insufficient standards of care for nursing homes, denial of residents' rights, and minimal public enforcement. Congress sought to remedy these longstanding limitations in federal law when it enacted FNHRA.

Congress recognized that private enforcement would be critical to ensuring that nursing home residents receive high quality care and protection of their rights. Through the language of the Construction Clause and placement of the Clause within the enforcement provisions of FNHRA, Congress confirmed both that private enforcement was one of the law's explicit enforcement options and that private enforcement, as implemented through litigation undertaken pursuant to 42 U.S.C. § 1983, would continue.

Congress recognized private litigation as a key component of FNHRA. Although FNHRA now sets out a public system for enforcing federal standards of care, two issues continue to make private enforcement an essential part of this comprehensive enforcement system.

First, enforcement of federal Requirements is still primarily focused on the most serious deficiencies – those called "actual harm" or "immediate jeopardy," the two classifications assigned to less than 5% of deficiencies that are cited.[85] Multiple reports of the Government Accountability Office in the 35 years since FNHRA was enacted document that public enforcement remains the rare response to facilities' noncompliance with Requirements.[86]

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[85] CMS, *Nursing Home Data Compendium 2015 Edition*, Figure 2.2.e, at 48, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/nursinghomedatacompendium_508-2015.pdf; HHS Office of Inspector General, *Trends in Deficiencies at Nursing Homes Show That Improvements Are Needed To Ensure the Health and Safety of Residents*, A-09-18-02010 (Apr. 2019), https://oig.hhs.gov/oas/reports/region9/91802010.pdf (in 2017, six percent of deficiencies were classified as "harm," "immediate jeopardy," or "no harm" with substandard quality of care).

[86] See, e.g., the following sample of GAO reports: *Federal and State Oversight Inadequate to Protect Residents in Homes with Serious Care Violations*, T-HEHS-98-219 (Jul. 28, 1998); *Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, HEHS-99-46 (Mar. 18, 1999); *Enhanced HCFA Oversight of State Programs Would Better Ensure Quality*, HEHS-00-6 (Nov. 4, 1999); *More Can Be Done to Protect Residents from Abuse*, GAO-02-312 (Mar. 1, 2002); *Prevalence of Serious Quality Problems Remains Unacceptably High, Despite Some Decline*, GAO-03-1016T (Jul. 17, 2003); *Despite Increased*

Second, even if enforcement were more consistently and effectively implemented to ensure greater compliance with federal Requirements, enforcement actions would not result in direct compensation to residents whose care is poor or whose rights are violated. The purpose of the public enforcement system is accountability to the public – protection of the broader public interest – not specific remedies for individuals who are harmed by their facilities' noncompliance with care standards or residents' rights.

IV. CONCLUSION

For these reasons, the Court should affirm the judgment of the Seventh Circuit.

Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety, GAO-06-117 (Dec. 28, 2005); *Some Improvement Seem in Understatement of Serious Deficiencies, but Implications for the Longer-Term Trend Are Unclear*, GAO-10-434R (Apr. 28, 2010); *Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse*, GAO-19-433 (Jun. 2019).

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