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
United States Court of Appeals
for the Seventh Circuit

BRIEF OF FORMER SENIOR OFFICIALS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICI CURIAE*[1]

Amici curiae listed in the attached Appendix are former senior officials of the United States Department of Health and Human Services ("HHS") or its predecessor, the Department of Health, Education, and Welfare ("HEW").[2] Each of the *amici* either exercised direct control over the administration of Medicaid or advised the Secretary of HEW or HHS on Medicaid policy.

Although *amici* hold different views about various aspects of Medicaid policy, we come together in this brief to support Petitioner's argument that Medicaid's rights-conferring provisions can and should be subject to private enforcement by beneficiaries under 42 U.S.C. § 1983.

Amici have ample experience administering the Medicaid Act[3] and believe that private enforcement has

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[1] Pursuant to Rule 37, counsel for *amici curiae* certifies that this brief was not authored in whole or in part by counsel for any party and that no person or entity other than *amici curiae* or its counsel has made a monetary contribution intended to fund the preparation or submission of this brief. All parties have consented to the filing of this brief.

[2] HEW was bifurcated into the Department of Education and the Department of Health and Human Services in 1979. The Centers for Medicare and Medicaid Services ("CMS")— the HHS agency that administers the Medicare and Medicaid programs—was known as the Health Care Financing Administration ("HCFA") from its inception in 1977 until July 2001. In the interest of descriptive accuracy, references to these agencies throughout the brief reflect their name at the relevant times.

[3] The term "Medicaid Act" or "Medicaid" is used to refer to the statutory provisions governing the Medicaid program found in Title XIX of the Social Security Act and codified at 42 U.S.C. § 1396 *et seq*.

played a crucial role in enforcing Medicaid's key provisions. *Amici* recognize the particular importance of private enforcement of the Federal Nursing Home Reform Act's ("FNHRA") "Residents' Bill of Rights." Private enforcement is integral to HHS's ability to enforce the FNHRA's requirements, particularly as states have demonstrated that they cannot function as reliable partners to enforce the federal mandate where they own or lease the very nursing homes subject to possible enforcement actions. In the collective experience of *amici*, the arguments advanced by respondents in this case are at odds with HHS's longstanding administrative practice. Worse, if they are adopted, they would seriously undermine enforcement of one of the most important statutes protecting the rights of some of this nation's most vulnerable individuals.

SUMMARY OF ARGUMENT

Medicaid, like other Social Security Act programs, originates from the Spending Clause. *See* U.S. Const. art. I, § 8. "Most of the major federal healthcare programs rely on Congress's ability to spend for the general welfare and to place conditions on the use of that money, including Medicare and Medicaid." Nicole Huberfeld, *Clear Notice for Conditions on Spending, Unclear Implications for States in Federal Healthcare Programs*, 86 N.C. L. Rev. 441, 474 (2008).

Codified as Title XIX of the Social Security Act, Medicaid is a cooperative program under which the federal government authorizes federal grants to states to provide health services to a diverse low-income population, including children, pregnant women, adults, individuals with disabilities, and individuals requiring

long term services and supports. *See* 42 U.S.C. § 1396a(a)(10)(A)(i) (identifying Medicaid-eligible populations); *see also* 42 C.F.R. § 430.0 (describing purpose of the Medicaid program).

For decades, this Court, Congress, states, and beneficiaries have understood that the substantive provisions of Spending Clause programs, including Medicaid, are rights-conferring, enabling private parties to remedy violations of these rights using the cause of action provided by 42 U.S.C. § 1983. *See Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502–03 (1990) (allowing providers to enforce the Boren Amendment to the Medicaid statute under § 1983); *see also* Brian J. Dunne, Comment, *Enforcement of the Medicaid Act Under 42 USC § 1983 after* Gonzaga University v. Doe*: The "Dispassionate Lens" Examined*, 74 U. Chi. L. Rev. 991, 1001 (2007) (noting that "lower courts throughout the early-to-mid-1990s generally allowed both providers and recipients to bring § 1983 suits to enforce many Medicaid Act provisions" and listing cases).

Throughout this time, Congress has built and expanded Medicaid (including through the enactment of the FNHRA). HHS's legal authority to administer Medicaid and other Social Security Act programs, as well as Congress's ongoing legislative reforms and amendments to these programs, developed against—and came to rely upon—the background availability of private enforcement.

Petitioners ask this Court to foreclose private parties from enforcing the rights conferred upon them by statute and relied upon by innumerable actors in this complex scheme. As Respondents ably explain in their brief, there is no legal basis for the Court to do so. But Petitioners also seek a ruling that threatens to

undermine the foundations of the cooperative framework underpinning Medicaid and like programs, creating widespread underenforcement far beyond the specific context of the FNHRA. Because the federal government has historically been able to rely on individual beneficiaries to enforce various Medicaid provisions, the existence of private enforcement has created important reliance interests.

The FHNRA is no exception. It was enacted as a direct response to the significant quality issues that had plagued nursing homes in the United States since the 1935 Social Security Act. To address the systemic failures identified in a 1986 Institute of Medicine study commissioned by Congress, the FNHRA set the standards for nursing home certification and accreditation, introduced new enforcement mechanisms, and most importantly, created a concrete and individualized "bill of rights" to protect residents in nursing homes. 42 U.S.C. §§ 1395i-3(c), 1395i-3(h); 1396r(h).

Yet despite the FNHRA's laudable goals, HHS has struggled to enforce the rights guaranteed by the statute due to practical constraints, most principally a lack of funding for enforcement actions. But unlike other Medicaid programs where HHS could rely on states to enforce federal laws—even if the states were not incentivized to always do so diligently—HHS cannot similarly depend on states to enforce the FNHRA. Rather than reliable partners in enforcement, states like Indiana have instead become *adversaries* to federal enforcement, as the states themselves own and lease the very nursing homes that, under the Medicaid statute, they are supposed to regulate. Private enforcement thus takes on even greater importance for the FNHRA.

Absent a private right of action, HHS would have no choice but to create a federal nursing home police force to the detriment of the taxpayer and those ill-served by nursing homes nationwide.

ARGUMENT

I. Private Enforcement of Rights Conferred by Spending Clause Legislation is Essential to HHS's Role in Administering Medicaid and Other Important Programs.

"Medicaid is a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals." *Wilder*, 496 U.S. at 502. While Congress could have enacted Medicaid as a top-down "exclusively federal" program (like Medicare) to cover low-income beneficiaries—creating a massive administrative and enforcement agency—it elected not to do so. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 630 (2012) (Ginsburg, J., dissenting). Instead, "[t]he Medicaid statute…is designed to advance cooperative federalism," and operates in a cooperative spending statutory scheme. *Wis. Dep't of Health & Fam. Servs. v. Blumer*, 534 U.S. 473, 495 (2002) (citing *Harris v. McRae*, 448 U.S. 297, 308 (1980)); *see also* Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gamble*, 81 Fordham L. Rev. 1749, 1761–67 (2013) (reviewing legislative history of Medicaid's enactment and noting the centrality of "cooperative federalism" principles).

Cooperative federalism spending legislation like Medicaid frequently takes the form of a "grant-in-aid" program, whereby Congress allocates specific

administrative authority to federal agencies to oversee the obligations and constraints on state policy implementation. Accordingly, Congress granted HHS the authority to administer the Medicaid program and oversee state Medicaid plans. This mandate is enormous, requiring HHS to supervise 56 individual state (and territorial) Medicaid programs which account for over $600 billion in Medicaid expenditures annually. *See* Medicaid.gov, *Annual Medicaid & CHIP Expenditures*, https://www.medicaid.gov/state-overviews/scorecard/annual-medicaid-chip-expenditures/index.html (last visited Sept. 21, 2022). As of May 2022, Medicaid covers 81.9 million people, more than a quarter of the United States population. *See* Medicaid.gov, *May 2022 Medicaid & CHIP Enrollment Data Highlights*, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html (last visited Sept. 21, 2022).

Medicaid and other cooperative spending programs create federal statutory rights for individual beneficiaries. For decades, § 1983 has provided a private cause of action for beneficiaries to vindicate violations of these rights, and private enforcement has served a distinct role in effectuating the programs' policy objectives. *See* Jon Donenberg, Note, *Medicaid and Beneficiary Enforcement: Maintaining State Compliance with Federal Availability Requirements*, 117 Yale L.J. 1498, 1502 (2008) ("Through § 1983, Medicaid beneficiaries have been able to operate as private enforcement agents, using litigation to supplant the traditional role of federal bureaucrats in enforcing the public interest as defined by Congress.")

Private enforcement plays a crucial role in Medicaid's statutory scheme, in part, because HHS lacks

the legal authority, logistical capacity, and practical ability to meaningfully remedy individual violations in many cases. Accordingly, Medicaid and other cooperative federalism programs rely on private enforcement to provide adequate and proportional remedies for violations of individual statutory rights.

Eliminating private enforcement would destabilize the balance Congress designed. The resulting underenforcement would leave millions of individuals, providers, and other beneficiaries more vulnerable to violations of their statutory rights, and raise the risk of waste, fraud, and abuse of Medicaid funds. Sole federal enforcement cannot mitigate these consequences absent a radical expansion of federal enforcement authority that would be incredibly costly and that is in any event incompatible with the core principles of cooperative federalism.

A. HHS cannot adequately remedy violations of individual rights or mitigate the consequences of underenforcement.

HHS's role in administering Medicaid and related Spending Clause rights-creating programs is neither structurally designed to protect—nor functionally capable of protecting—these rights in the absence of private enforcement.

The structure of cooperative federalism programs like Medicaid creates practical and political constraints on HHS's ability to respond to violations of individual beneficiaries' statutory rights, and a "general reluctance" in agency officials to utilize existing enforcement mechanisms. Dunne, *supra*, at 994–95; *see also* Edward A. Tomlinson & Jerry L. Mashaw, *The Enforcement of Federal Standards in Grant-in-Aid*

Programs: Suggestions for Beneficiary Involvement, 58 Va. L. Rev. 600, 619–20 (1972) (explaining that grant-in-aid programs are "meant to be cooperative efforts" and federal agencies are not "enforcement oriented.").

HHS has limited statutory authority to enforce Medicaid and remedy non-compliance. While an individual vindicating their statutory rights under § 1983 can seek either money damages or specific injunctive relief from ongoing or future violations, HHS lacks the statutory authority to pursue tailored judicial remedies. To the contrary, HHS's enforcement authority is largely limited—to "wield[ing] only the blunt and politically dangerous club of withholding federal funding." *See* Sasha Samberg-Champion, Note, *How to Read* Gonzaga*: Laying the Seeds of a Coherent Section 1983 Jurisprudence*, 103 Colum. L. Rev. 1838, 1858–59 (2003). "[T]he intended mechanism for keeping states accountable for their obligations under Medicaid is found in 42 U.S.C. § 1396c, which allows the Secretary of HHS, upon a sufficient finding of noncompliance, to withhold some or all of the federal government's grant payments." Donenberg, *supra*, at 1501; *see also* Katherine Moran Meeks, Case Note, *Private Enforcement of Spending Conditions After* Douglas, 161 U. Pa. L. Rev. Online 56, 59 (2012) ("CMS has only one tool to cudgel compliance … if the agency determines that a state's management of its Medicaid program has failed 'to comply substantially' with federal conditions, it may cease making all or part of the payments" to the state's program. (quoting 42 C.F.R. § 430.35(a) (enumerating bases for withholding payments))).

HHS is understandably hesitant to commence enforcement proceedings or withhold program funding. Not only do these enforcement mechanisms fail to

vindicate individual beneficiaries whose rights were violated, but they risk imposing further harm, by weakening or suspending the state programs on which beneficiaries have come to rely. *See Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 52 (1981) (White, J., dissenting) (characterizing withholding funds as "a drastic remedy with injurious consequences to the supposed beneficiaries" of spending clause programs). The limitation and severity of these penalties account, in part, for the reality that "agency action following state noncompliance is a rarity." Samberg-Champion, *supra*, at 1859*; see also* Nicole Huberfeld, *Post-Reform Medicaid before the Court: Discordant Advocacy Reflects Conflicting Attitudes*, 21 Annals Health L. 513, 522 (2012) (noting "total funding withdrawal has never happened … because CMS recognizes the draconian and counterproductive nature of penalizing states in this way.").

In addition to supplying an inadequate remedy to beneficiaries, exacting these harsh penalties on states risks imperiling other program priorities, including fraud prevention. *See, e.g.*, Meeks, *supra*, at 59 (noting that "[r]ather than strong-arm[ing] the states," CMS has historically preferred to "seek[] their cooperation through soft political persuasion" to promote state efforts to monitor and prevent Medicaid fraud). In promoting these goals, "[t]he posture of the federal agency toward its grantees is not generally that of a referee calling fouls, but that of a coach giving support in the form of cash and expertise." Edward A. Tomlinson & Jerry L. Mashaw, *supra*, at 619–20.

Second, and relatedly, practical constraints further limit HHS's and CMS's capacity to monitor and redress violations of beneficiaries' individual rights. Despite its

crucial role in administering Medicare, Medicaid, and CHIP, HHS has always faced challenges in securing adequate administrative resources for effective oversight and enforcement.

CMS is tasked with administering massive cooperative spending programs that represent substantial federal investment to provide or expand access to quality health services. Administering Medicaid, alone, requires CMS to oversee 56 individual state and territorial plans that receive nearly three-quarters of a trillion dollars in annual federal expenditures. *See* Medicaid.gov, Annual Medicaid & CHIP Expenditures, *supra*. Yet CMS has only a few hundred employees, operating on a relatively modest budget, dedicated to supervising Medicaid programs. As constituted, it simply does not have the capacity to fill the void if the private enforcement mechanisms on which the agency has come to rely were suddenly stripped away.

These practical constraints are inherent in the programmatic structure. Even as the Medicaid program receives and distributes hundreds of billions of dollars in mandatory spending, dedicated to funding services, HHS and CMS have always faced challenges in securing adequate discretionary funds to support their substantial administrative duties.

Under budgetary rules, the administrative expenses of Medicare and Medicaid are classified as "discretionary" spending, which must be appropriated on an annual basis. *See* Robin Rudowitz et al., Issue Brief–*Medicaid Financing: The Basics*, Kaiser Family Foundation (2021), https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/. During that process, CMS must compete for a limited pool of

discretionary funds with the Centers for Disease Control, the National Institutes of Health, the Food and Drug Administration, and other HHS agencies with compelling and often urgent priorities. This process renders the resources necessary for meaningful oversight of HHS's Spending Clause programs vulnerable to political and budgetary fluctuations.

B. Absent private enforcement, HHS would have to either abandon cooperative federalism or risk substantial wasteful outflows in mandatory spending.

Eliminating private enforcement of statutory rights enacted through Spending Clause legislation in general, or in the Medicaid context specifically, creates a risk of widespread underenforcement that would (1) harm individual beneficiaries; (2) put crucial federal expenditures dedicated to health care at a higher risk of waste and abuse; and (3) undercut the statutory purposes of the programs of providing necessary services.

Without the ability to rely upon the enforcement of rights guaranteed through Spending Clause programs like Medicaid by private beneficiaries, the federal government will be placed in an impossible position. It can either do nothing and let the fraud, waste, and abuse previously identified and abated by private actions fester (which would understandably diminish public confidence in the programs), or it can transform the role that HHS has traditionally played in the Medicaid program and create a massive new federal enforcement arm. There is no reason for this Court to put HHS to a choice between two equally undesirable alternatives.

As discussed, HHS faces serious constraints in establishing, scaling, and maintaining enforcement mechanisms and providing adequate remedies for individual beneficiaries' claims. In addition to providing a poor substitute for private enforcement, however, such an undertaking would require HHS to abandon the careful balance of national-and state-level cooperation, radically expanding the role of HHS in Medicaid enforcement, and risk jeopardizing other priorities. Within the cooperative federalism structure Congress created, HHS has partnered with states in critical programmatic goals, including fraud prevention. *See, e.g.*, Meeks, *supra*, at 59 ("Rather than strong-arm the states, the agency seeks their cooperation through soft political persuasion and directs its limited enforcement resources to preventing fraud by doctors, hospitals, and other private-sector providers."); Abigail R. Moncrieff, *The Supreme Court's Assault on Litigation: Why (and How) It Might Be Good for Health Law*, 90 B.U. L. Rev. 2323, 2340–41 (2010) ("CMS directs more of its Medicaid resources to policing individual providers' compliance with Medicaid fraud and abuse laws than policing state agencies' compliance with the federal statute. On the occasions that CMS does reject state plans or insist on amendments thereto, it almost always does so to protect its own funds from perceived state raids."); *see also* Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. Davis L. Rev. 413, 466 (2008) (documenting CMS's focus on fraud prevention in lieu of enforcement).

II. The FNHRA is a Prime Example of the Importance of Private Enforcement.

Private enforcement of Spending Clause legislation, then, is indispensable to HHS's ability to perform its

statutory obligations—and the FNHRA is no exception. HHS relies on the empowerment of private attorneys general to enforce the standards of care and individual rights that Congress guaranteed to vulnerable nursing home residents in the FNHRA.

A. Federal programs supporting nursing home care have long faced quality and enforcement issues.

The history of federal regulation of nursing homes has been marked by recurring and evolving struggles to ensure that nursing homes provided adequate care and satisfactory living conditions to their residents. The federal government's approach to nursing homes has always involved cooperation between the state and federal governments. The federal government's first true attempt at old age assistance began with the 1935 Social Security Act, which provided federal funds to states to facilitate direct financial assistance to individuals who were 65 or older. *See generally* Institute of Medicine, *Improving the Quality of Care in Nursing Homes* app. A at 238 (1986); Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid's History*, 26 Ga. St. U. L. Rev. 937, 942 & n.30 (2010). The Social Security Act embodied a new approach to social welfare that rejected the old system of public almshouses that isolated the needy from society, in favor of direct financial assistance intended to permit individuals to support themselves in the community. *See* Watson, *supra*, at 940–42. To that end, the 1935 statute expressly exempted from this old-age assistance program residents of public institutions to prevent "the use of the public poorhouse to care for the poor elderly." Institute of Medicine, *supra*, app. A at 238. Despite the vision that individuals—with the help of

federal funds—would no longer need institutionalized care, "[i]t quickly became apparent that many of the frail elderly needed more care and support than could be provided at home, and new private institutions stepped in to fill the void." Watson, *supra*, at 944.

In this way, the Social Security Act helped to create the modern American nursing home industry, and the cooperative federal/state framework that still defines that industry today. Under the Social Security Act, states designed and administered programs jointly funded by the state and federal governments, and states that opted in operated under state plans approved by the federal government. Federal laws set minimum requirements, but the states retained great discretion. *Id.* at 942–43. From the beginning, the federal government has thus relied on state cooperation to regulate nursing homes, and continues to largely depend upon state cooperation to regulate these facilities. *See id.* at 945–52; Institute of Medicine, *supra*, at 238–39.

For example, the 1950 Amendments to the Social Security Act required states to create nursing home licensing programs, but left it to the states to determine the standards and enforcement procedures for themselves. Institute of Medicine, *supra*, at 238. Likewise, the 1960 Kerr-Mills Act set additional federal minimum standards, but still left states the discretion to "define the various categories of medical assistance and set licensing standards." Watson, *supra*, at 948–50. In the lead up to the Medicaid Act in 1965, there were growing concerns about the quality of nursing homes, including "about the adequacy of state licensing standards and the variability of state enforcement." Institute of Medicine, *supra*, at 240.

The significant expansion of federal support and involvement in nursing homes following the passage of the Medicaid program in 1965 did not resolve these persistent issues plaguing the system. It was not until the 1967 Moss amendments to the Medicaid program that the federal government finally "develop[ed] standards and regulations to be applied uniformly by the states," and not until the 1970s that pressure to "increase the standards for nursing homes participating" in Medicaid to "improve their enforcement" truly began to build. *Id.* at 241–42. Work did not begin "in earnest to develop" federal regulations governing nursing homes until 1972, and even until 1974, "states were able to use their discretion in allocating Medicaid funds to support residents in facilities" not meeting federal standards. *Id.* at 244–45. In other words, the federal government did not establish uniform national standards to regulate the quality of nursing homes until the mid-1970s. By that point, serious breakdowns in the quality of care provided by nursing homes had become a nationwide problem. *See, e.g.*, Bruce C. Vladeck, *Unloving Care: The Nursing Home Tragedy* (1980).

Against that backdrop, in 1986, Congress commissioned the Institute of Medicine to conduct a study of government regulations of nursing homes and recommend changes in regulatory practices and procedures to improve the quality of care provided in these facilities. *See* Institute of Medicine, *supra*, at 1–2, 2 n.1. The study exposed the dire need for reform, finding that "[d]espite extensive government regulation for more than 10 years, some nursing homes can be found in every state that provide seriously inadequate quality of care and quality of life." *Id.* at 21. To rectify the

situation, the study concluded that while the "[r]egulation of nursing homes both by state and federal governments is necessary to assure safety and acceptable quality of care for nursing home residences because of the vulnerability of the residents," "[a] stronger federal leadership role is essential for improving nursing home regulation because not all state governments have been willing to regulate nursing homes adequately unless required to do so by the federal government." *Id.* at 21–22.

As a direct result of this pivotal study, the following year Congress enacted the Federal Nursing Home Reform Act ("FNHRA") as a part of the Omnibus Budget Reconciliation Act of 1987. 42 U.S.C. § 1395i-3, Pub. L. No. 100-203, tit. IV, subtit. C, 101 Stat. 1330, 1330-160 (1987). The legislative history makes clear that the Omnibus Budget Reconciliation Act's "provisions designed to improve the quality of nursing home care" directly implemented the "comprehensive study [conducted] by the Institute of Medicine." H.R. Rep. No. 100-391(I), at 382 (1987), *as reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-202. To that end, the FNHRA created a concrete and individualized "bill of rights" for residents in nursing homes and long-term care facilities, including the right to freedom from abuse, mistreatment and neglect and the right to self-determination. *See* 42 U.S.C. § 1395i-3(c). The statute also set standards for the certification and accreditation of these facilities and introduced new enforcement mechanisms that were implemented in subsequent regulations. Under the FNHRA's enforcement framework, HHS provides direction and oversight of state regulators, who in turn implement surveys, compliance, and enforcement actions against facilities.

42 U.S.C. § 1395i-3(h). HHS is only armed with a limited set of blunt tools to enforce the FNHRA's requirements, such as the partial and full denial of payments to noncomplying facilities, or civil penalties. 42 U.S.C. § 1395i-3(h).

B. While the FNHRA advances Congress's admirable goal of comprehensive reform of nursing homes, HHS has struggled to enforce the rights guaranteed under the statute.

Twenty years after the FNHRA's passage, the Government Accountability Office ("GAO") conducted a study which found some progress since 1986, but also discovered that "a small but significant share of nursing homes nationwide continues to experience quality-of-care problems." Kathryn G. Allen, U.S. Gov't Accountability Office, GAO-07-794T, *Nursing Home Reform: Continued Attention Is Needed to Improve Quality of Care in Small but Significant Share of Homes* 1 (2007), https://www.aging.senate.gov/imo/media/doc/hr172ka.pdf. GAO found that HHS's "sanctions policy is complex and appears to have induced only temporary compliance in certain nursing homes with histories of repeated noncompliance," that the threat of "immediate sanctions" was ineffective to the extent that it required "only that homes be notified immediately of HHS's intent to implement sanctions, not that sanctions be implemented immediately," and that when sanctions were actually implemented, "there is a lag time between when the deficiency citations occurs and the effective date of the sanction." *Id.* at 3.

These enforcement woes are further exacerbated by HHS's limited resources. As GAO noted, "[t]o increase its oversight of quality of care in nursing homes, CMS

has focused its resources and attention" on key areas, "such as prompt investigation of complaints and allegations of abuse," but "this increased emphasis on nursing home oversight coupled with growth in the number of Medicare and Medicaid providers has caused greater demand on limited resources." *Id.* at 3–4.

These funding constraints have only worsened over time. As overall Medicaid spending has doubled over the last ten years, from $268 billion in FY 2011 to $521 billion in FY 2021, the amount allocated to CMS for administrative oversight of that spending has failed to keep up the pace, rising just $3 million from $145 million in 2011 to just $148 million in 2021. *Compare* Centers for Medicare & Medicaid Services, *Financial Report: Fiscal Year 2011*, at 63 (2011), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/CFO-Report-2011-.pdf *with* Centers for Medicare & Medicaid Services, *Financial Report: Fiscal Year 2021*, at 46 (2021), https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2021.pdf. Far from alleviating funding constraints, the expansion of federal Medicaid spending without an increase of funds to administer this sprawling program has exacerbated CMS's enforcement problems. Despite being entrusted with the significant task of implementing the FNHRA's statutory commitments to nursing home residents, HHS faces a constant uphill struggle to do so given its inefficient enforcement tools and lack of adequate resources to sustain its mandated—and essential—oversight efforts.

C. Private enforcement is necessary to enforce the FNHRA because states like Indiana function as adverse parties rather than cooperative partners enforcing federal law.

Given HHS's limitations, adequate enforcement by the states is critical to the FNHRA's enforcement. But in reality, states are far from the reliable partners envisioned by cooperative federalism.

Under a properly functioning cooperative federalism framework, states act together *with* the federal government as allies in enforcement. Both governments ought to have an interest in properly regulating private actors, as a majority of nursing homes are. In such cases, a private right of action is not available under § 1983 because there is no state actor, but the state is incentivized to enforce the FNHRA's mandates alongside the federal government *against* the private-sector owners.

Even still, state oversight is often flawed. For instance, state surveys of nursing homes—a key component of the FNHRA's enforcement mechanism—frequently understate the number or level of deficiencies in facilities, either by failing to cite a deficiency, or by citing the deficiency at too low of a level. U.S. Gov't Accountability Office, GAO-10-434R, *Nursing Homes: Some Improvement Seen In Understatement Of Serious Deficiencies, But Implications For The Longer-term Trend Are Unclear* 1 (2010), https://www.gao.gov/assets/gao-10-434r.pdf. Thus, even when cooperative federalism functions as intended and states serve as joint overseers, existing federal and state oversight alone has regularly fallen short of ensuring the FNHRA's full enforcement.

But many state and local governments are incentivized to abandon their role in the cooperative federalism scheme when they do not just *regulate* nursing homes, but also own, lease, or operate nursing homes themselves. Under these circumstances, cooperative federalism tends to break down because the state government is acting as both the regulated party and the regulator. A state's incentives to turn a blind eye to infractions and only weakly enforce the FNHRA's mandates where the state itself owns and operates the nursing homes at issue are undeniable.

Medicaid is the primary funding source for the majority of nursing homes in the United States. *See* Kaiser Family Foundation, *Medicaid's Role in Nursing Home Care* (2017), https://www.kff.org/infographic/medicaids-role-in-nursing-home-care/. Over 1.4 million individuals live in over 15,500 Medicare- and Medicaid-certified nursing homes, and more than 60% of nursing home residents are covered by Medicaid. *Id.* Enforcement actions that jeopardize such significant federal funding are naturally antithetical to the state's interest when the state owns, operates, or leases the problematic facilities and relies on federal payments. Indeed, there is a long history of states misusing (or otherwise exploiting) mechanisms to "maximize" intergovernmental transfer funds, particular in the context of Medicaid. *See, e.g.*, Daniel L. Hatcher, *Medicaid Maximization and Diversion: Illusory State Practices That Convert Federal Aid into General State Revenue*, 39 Seattle U. L. Rev. 1225, 1250–58 (2016); Kathryn G. Allen, U.S. Gov't Accountability Office, GAO-05-836T, *Medicaid: States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight* 7 (2005), https://www.gao.gov/assets/

gao-05-836t.pdf ("As various schemes involving [intergovernmental transfers or] IGTs have come to light, Congress and CMS have taken actions to curtail them, but as one approach has been restricted, others have often emerged.").

Compounding the problem, state ownership of nursing homes is currently *incentivized* by the Medicaid regime—facilities that are owned or leased by state or local governments are entitled to higher Medicaid reimbursement rates than nursing homes that are privately owned. *See* Phil Galewitz, *Chasing Millions in Medicaid Dollars, Hospitals Buy Up Nursing Homes*, Kaiser Family Foundation (Oct. 19, 2017). Nowhere is this incentive structure evidenced more clearly than in Indiana. While most nursing homes are privately owned in most other parts of the country, over 93% of Indiana's nursing homes are owned or leased by governmental entities. Tim Evans et al., *Nursing Home Residents Suffer As County Hospitals Rake In Millions*, Indianapolis Star (Mar. 11, 2020), https://www.indystar.com/in-depth/news/investigations/2020/03/11/indiana-nursing-home-patients-suffer-medicaid-money-diverted-hospitals/2517834001/.

This was no accident. The Health and Hospital Corporation of Marion County ("HHC"), a municipal agency (and one of the Petitioners here), intentionally targeted "low-income, elderly residents in for-profit nursing homes across Indiana" as prime revenue sources and began "buying for-profit nursing homes … all across the state" and "worked with state officials to turn poor-performing nursing homes into a revenue opportunity, taking advantage of federal Medicaid funding policies." Hatcher, *supra* at 1251. Indiana's goal was clear: "Purchase nursing homes so they are government-

owned, which would lead to an increase in federal Medicaid funds. Then, route the money to other uses, rather than to nursing home care." *Id.* at 1252; *see also* Evans, *supra* (describing HHC's plan of "buying nursing homes, at least on paper, to qualify for [Medicaid] funds," then "exploit[ing] lax federal and state rules that allowed the hospital to pocket much of the money").

While Indiana stands out for the pervasiveness of the practice, other states have adopted (or are considering) similar programs. For example, between 2014 and 2015, Texas lawmakers facilitated the "Minimum Payment Amounts Program," and about one-fifth of Texas nursing facilities transferred legal ownership to local counties or hospital districts, increasing protection of the facilities under the state's provisions permitting only limited causes of action against local governments. *See* Edgar Walters, *Funding Program Shields Nursing Homes from Lawsuits*, Tex. Trib. (May 24, 2015), https://www.texastribune.org/2015/05/24/funding-arrangement-shields-nursing-homes-lawsuits/.

The point is not that these states are acting inappropriately; it is that they have perverse incentives *as regulators* in the cooperative federalism scheme contemplated by the FNHRA. Nursing homes are encouraged to be state-owned or leased to gain higher federal reimbursement rates, while states are simultaneously enticed to laxly enforce the FNHRA's requirements against their own facilities—against *themselves*—lest they face sanctions and lose federal funding.

In jurisdictions like Indiana, where the overwhelming majority of nursing homes are state-controlled and 62% of nursing home residents are on

Medicaid, the state is simply not incentivized to perform their responsibilities under the FNHRA as government partners regulating private entities. Indeed, after Indiana began owning and leasing nursing homes, concerns about the diversion of funds materialized. Again, because the purpose of HHC's takeover of private nursing homes was to maximize federal funds, the agency "was primarily focused on increasing cash flow," not "on improving quality of care of its health facilities." Hatcher, *supra* at 1252–53. Despite the fact that HHC's purchase of a private nursing home "can immediately lead to an additional $55 in federal Medicaid payments per day per nursing home resident," the agency then "diverted most of the extra money away from the nursing homes, using the funds for other purposes such as a new $750 million dollar hospital complex." *Id.* at 1254.

Far from protecting its nursing home residents, Indiana has "left the residents in poor care while their federal aid was diverted." *Id.* As a 2020 investigation by The Indianapolis Star found, the state's ownership of its nursing homes has left it "with some of the worst nursing homes in America," turning into an "end-of-life nightmare" for nearly 39,000 Indiana nursing home residents. Evans, *supra*. Facilities are "dangerously understaffed … [such that] basic standards of care, such as assisting residents to avoid falls or turning immobile patients to prevent bedsores, are often neglected," patients are "wasting away from inattention to dietary needs," and residents have fallen and broken bones "but were left untreated for hours or days." *Id.* Far from a partner to HHS, Indiana is essentially an adverse party with little incentive to stop siphoning funds away from nursing homes, let alone report or correct its own

violations inuring to its own benefit. Thus, the reality is that in states like Indiana, contrary to the Solicitor General's position as an *amicus* in this case, the FNHRA's protections do not have "only limited application to state and local entities" because states have learned to exploit a loophole to undermine the assumption that FNHRA will "offer protection primarily against *private* parties." Br. for the United States as Amicus Curiae Supporting Neither Party 29.

D. Absent private enforcement, many of the most vulnerable Americans will be deprived of the FNHRA's protections.

Under current law, the only realistic solution for systemic failures of regulation like those in Indiana is private enforcement.

Absent private enforcement, the burden would fall on the federal government to develop the enormous law enforcement operation necessary to police the over 15,000 nursing homes receiving federal funding. As with other Spending Clause legislation, sole federal enforcement is neither feasible nor compatible with the FNHRA's cooperative federalism scheme. But the need is more dire in the context of the FNHRA, where, as explained above, the state's ownership of nursing homes has created a fox-guarding-the-hen-house problem.

In that respect, the FNHRA is distinct, and particularly reliant on private enforcement. Under many other HHS-enforced programs, a state may be more or less cooperative in enforcing federal mandates. By contrast, states that own or lease nursing homes are uniquely positioned in the FNHRA framework, and may adopt a directly adversarial posture. Under these circumstances, there is no universe in which the

FNHRA scheme could ever be comprehensive or effective *without* private enforcement. *Cf. Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320 (2015) (holding that Medicaid's equal access provision is not subject to private enforcement because alternative enforcement mechanisms displace a traditional equitable action). Thus, the lack of private enforcement would lead either to the FNHRA's protections becoming moribund or the need for HHS to create a sprawling federal nursing home enforcement agency to police states. Such a ubiquitous federal nursing home police force is not just radically inconsistent with the historic mission of HHS and the structural relationships underlying the Medicaid program; it would also unnecessarily *increase* the federal government's footprint in private businesses.

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That the FNHRA permits—and assumes—private rights of action is entirely consistent with the statutory language and legislative history. *See* Br. for Resp't. But our experience administering HHS has taught us that these actions are not just *useful* for proper enforcement of this vital legislation; they are necessary. The alternatives—that these rights go completely unenforced or that a massive federal law enforcement agency is created to enforce them—should be equally undesirable to all.

CONCLUSION

For the foregoing reasons, the judgment below should be affirmed.

Respectfully submitted,

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APPENDIX

APPENDIX

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