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 INDIANA DISABILITY RIGHTS AS AMICI CURIAE IN SUPPORT OF RESPONDENT

MELISSA L. KEYES
Executive Director
THOMAS E. CRISHON
Legal Director
EMILY A. MUNSON
Policy Director
Counsel of Record
INDIANA DISABILITY RIGHTS
4755 Kingsway Drive
Ste. 100
Indianapolis, IN 46205
(317) 504-2578
EMunson1@
IndianaDisabilityRights.org

Counsel for Amici Curiae

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INTEREST OF INDIANA DISABILITY RIGHTS

Indiana Disability Rights[1] (IDR) is the federally mandated Protection and Advocacy (P&A) system and Client Assistance Program (CAP) for individuals with disabilities in Indiana. Congress established P&A and CAP agencies in every state and territory, as well as the District of Columbia and the Navajo, Hopi, and San Juan Southern Paiute Reservations, to provide individuals with disabilities and their family members with legal representation, advocacy, education, and referral services regarding relevant disability rights issues. *See* 42 U.S.C. § 15041 *et seq*.; *see also* 29 U.S.C. § 732. IDR has authority to monitor locations in which individuals with disabilities are receiving services, including nursing facilities. *See* 45 C.F.R. § 1326.27(c); *see also* 42 C.F.R. § 51.42(c). In addition to its monitoring activities, IDR regularly represents individuals with disabilities whose rights have been violated by Medicaid providers, state Medicaid officials, nursing facility operators, and other entities acting within the context of programs created through the Spending Clause. Consistent with its Vision, "[t]o live in a fully accessible, equitable society where people with disabilities are free from abuse and neglect, are free to be effective advocates, and are free to fully exercise their civil, legal, and human rights, ensuring full inclusion," IDR's interest is to protect and enforce the rights of individuals with disabilities, including those granted through programs passed using the Spending Clause, such as Medicaid.

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[1] Pursuant to Rule 37.6, counsel for *amicus curiae* state that none of the parties' counsel authored this brief in part or whole and that no person other than IDR made a monetary contribution to its preparation and submission. All parties consented to the filing of amicus briefs.

SUMMARY OF THE ARGUMENT

IDR supports the Respondent and *amici* legal arguments regarding the merits of the Seventh Circuit's decision. Rather than reconstrue those arguments and offer similar precedent, IDR appears as *amicus* to share with the Court what it knows best: the rights violations that deter Hoosiers with disabilities from living more active and engaged lives in their communities. Sadly, the facts underlying Gorgi Talevski's case are not unusual; an entire vocabulary, which includes phrases like "chemical restraints" and "patient dumping," has developed to describe nursing facility industry norms.

The questions at issue in this case, however, have expanded the decision's potential reach. Rather than focusing on Mr. Talevski and his Section 1983 suit to enforce the Federal Nursing Home Reform Act's (FNHRA) Residents' Bill of Rights, the Court granted *certiori* to consider whether any individual may bring a private right of action under Section 1983 to enforce their rights under any program Congress created with the Spending Clause. This inquiry will affect more than eighty-eight million people.[2] This figure does not include providers but, like this brief, represents program beneficiaries, who are often low-income and marginalized by disability and/or age.

Like Mr. Talevski, Hoosiers with disabilities have historically had to use their private right of action to

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[2] More than 88,978,000 individuals were enrolled in Medicaid and the Children's Health Insurance Programs (CHIP), just two of many programs involving the Spending Clause, as of May 2022. *May 2022 Medicaid & CHIP Enrollment Data Highlights*, U.S. DEPT. OF HEALTH AND HUMAN SVCS. (accessed: Sept. 10, 2022), https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

remedy rights violations. Section 1983 was the mechanism through which Hoosiers with disabilities ultimately recovered promised benefits like attendant care, *see Chadwell v. Ind. Family & Social Svcs. Admin.*, No. 11D01-0808-PL-373 (Clay Cnty. Super. Ct. 2010); hepatitis C drugs, *see Selner v. Sec'y of the Ind. Family & Social Svcs. Admin.*, No. 1:15-cv-01874-SEB-MPB (S.D. Ind. 2019); and medically-necessary dental services, *see Bontrager v. Ind. Family & Social Svcs. Admin.*, 697 F.3d 604 (7th Cir. 2012). Without Section 1983, affected beneficiaries would have respectively been needlessly institutionalized, made to endure liver damage, and lose alimentary function. Given the critical nature of Medicaid benefits, several affected beneficiaries also likely would have died without needed services.

Administrative enforcement mechanisms alone are insufficient to render relief to Spending Clause program beneficiaries. Quite simply, the procedures provided in statutes like FNHRA do not offer appropriate relief for individual and systemic rights violations. These procedures' lack of robust administrative oversight will only be exacerbated as the U.S. population continues to age and develop disabilities. Section 1983 is critical to address rights violations, maintain intergovernmental checks and balances, and to foster cooperation between those most affected by Spending Clause programs. The abolition of a private right of action to enforce these programs would obliterate beneficiaries' rights.

ARGUMENT

I. More than one million Hoosiers – and millions more nationwide – will be adversely affected if the Court overturns precedent to preclude private enforcement of rights pursuant to Section 1983.

A. Hoosiers participating in various Spending Clause programs have had to rely on Section 1983 to enforce their rights.

Medicaid, enacted as title XIX of the Social Security Act, is a federal-state partnership that provides medical assistance to eligible participants. In April 2022, more than eighty-eight million individuals were enrolled in Medicaid programs nationally. Henry J. Kaiser Family Foundation, *Analysis of Recent National Trends in Medicaid and CHIP Enrollment* (Aug. 3, 2022), https://kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-Medicaid-and-chip-enrollment/. Medicaid was the third most popular form of health insurance among Hoosiers in 2020. *See* Kathrine Keisler-Starkey and Lisa N. Bunch, *Health Insurance Coverage in the United States: 2020*, U.S. Census Bureau, at 3 (Sept. 2021), https://www.census.gov/content/dam/census/library/publications/2021/demo/p60-274.pdf. As of May 1, 2022, Indiana had more than 1,829,000 beneficiaries. Centers for Medicare and Medicaid Services, *State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data*, U.S. DEPT. OF HEALTH AND HUMAN SVCS. (updated Aug. 25, 2022), https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360/data.

Hoosier Medicaid beneficiaries are diverse. One in eight adult residents between the ages of 19 and 64, as well as one in three child residents, is enrolled in

Indiana Medicaid. *See* Henry J. Kaiser Family Foundation, *Medicaid in Indiana* at 2. More than 40% of Hoosier children with specialized medical needs are Medicaid beneficiaries, as are two of three Hoosier nursing facility residents. *Id*. One-third of Hoosiers with a disability also participates in Indiana Medicaid. *Id*.

As a cooperative partnership, the federal government requires that States participating in Medicaid make certain mandatory services available to all beneficiaries, while each State can choose to add additional services from an optional menu. Mandatory Medicaid benefits include inpatient and outpatient hospital services; early and periodic screening, diagnostic, and treatment services; physician services; home health care; and nursing facility services. Indiana offers an array of optional benefits, too, including prescription drugs; dental services; physical therapy; and inpatient psychiatric services for individuals younger than 21 years.

Numerous times, Hoosier Medicaid beneficiaries have had to invoke 42 U.S.C. § 1983 to enforce germane rights granted by Congress. In *A.M.T. v. Gargano*, 781 F.Supp.2d 798 (S.D. Ind. 2011), a class of children with severe physical disabilities maintained that Indiana's Medicaid program violated their rights by curtailing occupational and/or physical therapy services that did not result in functional progression but did halt significant regression. The district court agreed, via summary judgment, and enjoined the State from enforcing its prohibition of maintenance therapy services. In *Chadwell,* No. 11D01-0808-PL-373, a class of Medicaid beneficiaries relying upon attendant care services to complete activities of daily living challenged Indiana's 40-hours-per-

week attendant care limit. The court ultimately granted summary judgment in the class' favor, saving its members from involuntary and needless transfer from their homes into institutional settings. *Chadwell* did not prevent Indiana's attempts to unlawfully capitate other Medicaid services. The State instituted an annual $1,000-per-beneficiary limit on dental services. A beneficiary precluded from receiving medically necessary dental services under this cap successfully claimed the policy violated federal Medicaid law in *Bontrager,* 697 F.3d at 612. In another case involving dental services, *McArty v. Roob*, No. 49D04-0606-PL-24259 (Marion Cnty. Super. Ct. 2007), a class of Medicaid beneficiaries who needed dentures or repairs to their dentures sought to overturn Indiana Medicaid's rule that such services be provided only once every six years. The case was resolved through a consent decree, in which Indiana agreed to cover medically necessary dental services without regard to the six-year restriction. In *Selner,* a class of beneficiaries sued because Indiana Medicaid denied them revolutionary hepatitis C medications. Pursuant to a settlement agreement, the State agreed to discontinue its practice of approving the drugs only for beneficiaries with substantial liver damage.

Hoosier Medicaid beneficiaries have also relied upon 42 U.S.C. § 1983 to enforce federal timeliness standards. In particular, cases were filed to enforce federal time limits regarding Medicaid eligibility decisions (*Thornton v. Murphy*, No. 1:08-cv-01853-LJM-DML (S.D. Ind. 2009)) and appeals (*Murray v. Roob*, No. 49D12-0505-PL-16671 (Marion Cnty. Super. Ct. 2012)). Ultimately, both cases were resolved in a manner favorable to the plaintiff beneficiaries.

Yet Medicaid is just one of many Spending Clause programs implicated by the instant case. The Supplemental Nutrition Assistance Program (SNAP), 7 U.S.C. § 51 *et seq*., which provides food assistance to low-income beneficiaries, is another. Although the U.S. Department of Agriculture administers SNAP through its Food and Nutrition Service, the individual distribution of SNAP benefits is conducted by the States.

In July 2022, 288,743 Hoosier households – or 613,106 individuals – received SNAP benefits. Division of Family Resources, *Statewide Monthly Management Report: July 2022*, IND. FAMILY AND SOCIAL SVCS. ADMIN. at 5 (Aug. 2022), https://www.in.gov/fssa/dfr/files/mmr-statewide-en-us-July-2022.pdf. An additional 21,030 applications for SNAP benefits were received that month. *Id*. The average SNAP benefit per Hoosier beneficiary is $165.60 per month. *Id*. Nationally, more than 41 million individuals rely on SNAP benefits, each receiving an average $217.88 per month. Food and Nutrition Services, *SNAP Data Tables*, U.S. DEPT. OF AGRICULTURE (updated Aug. 12, 2022), https://fns.usda.gov/pd/supplemental-nutrition-assistance-program-snap (click the table titled *National Level Annual Summary: Participation and Costs, 1969-2021*).

Like their Medicaid counterparts, Hoosier SNAP beneficiaries have relied upon their private right of action available through Section 1983 to make Indiana operate the program as intended. In *Nickels v. Roob*, No. 49D01-0701-PL-4025 (Marion Cnty. Superior Ct. 2007), a class of SNAP beneficiaries filed a lawsuit because Indiana was taking longer than the statutory timeframe to resolve appeals. The court approved a consent decree that enjoined the State from failing to prioritize beneficiary appeals of SNAP adverse actions.

In addition to generally well-known, widely-utilized programs like Medicaid and SNAP, the questions posed by Respondents implicate a variety of lesser-known – but not less essential – programs. For example, Title IV-E of the Social Security Act, 42 U.S.C. § 670 *et seq*., requires participating States to pay for certain costs for children in foster care and provide payments on behalf of adopted children with special needs.

In *C.H. v. Payne*, 683 F.Supp.2d 865 (S.D. Ind. 2010), several classes of foster children, children with special needs, and their parents, challenged Indiana's reduction in mandatory payments. More specifically, the classes maintained that the payments had been reduced to a level that was insufficient to meet the children's basic needs. The Indiana Association of Residential Child Care Agencies, Inc. also filed a case regarding provider payments that was consolidated with *C.H. See The Indiana Association of Residential Child Care Agencies, Inc. v. Ind. Dept. of Child Svcs. and Hon. James Payne, Dir.,* 683 F.Supp.2d. 865 (S.D. Ind. 2010). The district court issued a preliminary injunction against these payment reductions. Again, without the private right of action available through Section 1983, Indiana foster children and children with special needs, as well as their parents, would not have obtained justice.

Notably, the twenty-two States appearing as *amici* to Petitioners, led by Indiana's Attorney General, also cite several cases in which Section 1983 was used to enjoin the State from amending its Medicaid plan to restrict services. States' *Amici* Merits Br. at 25-28. Each of the cases cited by the States was filed by an abortion provider, despite the fact that the issues raised in the instant case affect far more than

Medicaid providers performing procedures that may be optional. When the States refer to "private beneficiaries [who] file enforcement actions under Section 1983," *id*. at 24, they appear to mean individuals that provide, or that would be in a position to provide, services to Medicaid recipients. Yet, this exclusive focus on Medicaid providers obscures the broader interests at issue. Even if the Court accepts the States' flawed premise that Medicaid providers can exploit Section 1983 to circumvent other political channels, removing that mechanism should not come at the expense of millions of beneficiaries who rely upon Spending Clause programs for essential medical care, nutrition, and other critical social services. Section 1983 is effectively the only tool these beneficiaries have to enforce their civil rights.

B. Most Indiana nursing facilities are publicly owned, generating enhanced Medicaid payments for the owners, yet these facilities often fail to provide residents the minimum standard of care.

Indiana spends more than $11 billion on Medicaid services annually. Henry J. Kaiser Family Foundation, *Medicaid in Indiana*, *supra*. While only one-quarter of Hoosier Medicaid beneficiaries are elderly and/or disabled, their services account for nearly three-quarters of Medicaid expenditures. *Id*. In 2019, Indiana Medicaid spent nearly $4.5 billion on long-term services and supports. Centers for Medicare and Medicaid Services, *Medicaid Long Term Services and Supports Annual Expenditures Report*, U.S. DEPT. OF HEALTH AND HUMAN SVCS., at 101 (Dec. 9, 2021), https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltsexpenditures2019.pdf. That sum

represents a 6.9% spending increase on long-term supports and services from the prior fiscal year. *Id*.

An *Indianapolis Star* investigative report found that more than twenty municipal entities now own 93% of the state's nursing homes, such as the Health and Hospital Corporation of Marion County (HHC), a Petitioner. *See* Tim Evans, Emily Hopkins, and Tony Cook, *Careless: Nursing Home Residents Suffer as County Hospitals Rake in Millions*, Indianapolis Star (updated Feb. 2, 2021), https://www.indystar.com/in-depth/news/investigations/2020/03/11/nursing-home-patients-suffer-medicaid-money-diverted-hospitals/2517834001/. As local government nursing facility owners, counties are eligible for increased Medicaid payments. *See* 42 C.F.R. § 447.272. In fiscal year 2020, Indiana received the fifth most of these enhanced payments in the country, earning approximately $669 million. *See* Medicaid and CHIP Payment and Access Commission, *Medicaid Base and Supplemental Payments to Hospitals* (May 2022), https://www.macpac.gov/wp-content/uploads/2022/05/Base-and-supplemental-payments-to-hospitals.pdf. Nonetheless, rather than apply these funds to improve nursing facility conditions, Indiana counties have diverted significant portions of the enhanced Medicaid payments to other projects. *See* Tim Evans, Emily Hopkins, and Tony Cook, *Careless, supra*. HHC, in particular, spent substantial proceeds "on other projects . . . , including the crowning achievement of [former HHC president and Chief Executive Officer Matthew] Gutwein's career, the $754 million Sidney & Lois Eskenazi Hospital in Indianapolis." Tim Evans, Tony Cook and Emily Hopkins, *HHC Leader Matthew Gutwein Resigns under Pressure*, Indianapolis Star (updated Jan. 23, 2021), https://www.indystar.com/story/news/investigations/2020/08/24/hhc-leader-matthew-gutwein-resigns/3413891001/. The money these

nursing facilities generate is diverted by their public entity owners, such that the nursing facilities subsidize extensive unrelated projects at the expense of their ailing residents. *See* Tim Cook, Emily Hopkins, Tony Cook, *Careless, supra.*

While HHC and other nursing facility owners allocate enhanced Medicaid reimbursements elsewhere, facility residents suffer. Approximately 11% of Indiana's nursing facility residents live in HHC-owned properties. *Id*. Yet 23% of the nursing facility deaths due to COVID-19 involved residents of those properties. *Id*. Moreover, while around 40% of national COVID-19 deaths were associated with nursing facilities nationally, approximately 60% of Indiana's deaths caused by COVID-19 were attributed to nursing facility residents and staff. *See* IN.gov, *Indiana COVID-19 Home Dashboard* (updated Aug. 16, 2022), https://www.coronavirus.in.gov/indiana-covid-19-dashboard-and-map/; *see also* Centers for Medicare and Medicaid Services, *COVID-19 Nursing Home Data*, U.S. Dept. of Health and Human Svcs. (updated Sept. 4, 2022), https://data.cms.gov/covid-19/covid-19-nursing-home-data. Perhaps this should not be surprising; over one-third of Indiana's nursing facilities failed to maintain required infection controls and received related citations in the three years prior to the pandemic.[3] *See* U.S. Gov't. Accountability Office, GAO-20-576R,

[3] During a pandemic press conference, Commissioner of the Indiana Department of Health (IDOH) Dr. Kristina Box minimized the high rate of nursing facility infection control failures by calling them "normal." Emily Hopkins and Tim Evans, *Long Before Coronavirus, Indiana's Had Staffing, Infection Control Issues*, INDIANAPOLIS STAR (updated Mar. 27, 2020), https://www.indystar.com/story/news/health/2020/03/17/coronavirus-indiana-nursing-homes-many-had-infection-control-issues/5040929002/.

Nursing Home Infection Control (2020), https://www.gao.gov/assets/gao-20-576r.pdf.

Indiana is one of eighteen states without a minimum direct care staffing mandate. *See* The National Consumer Voice for Quality Long-Term Care, *State Nursing Home Staffing Standards* at 6 (accessed Sept. 20, 2022), https://theconsumervoice.org/uploads/files/issues/CV_StaffingReport.pdf. Even before the pandemic, Indiana nursing facilities were rated among the nation's worst. *See* AARP et al., *Long Term Services & Supports State Scorecard* (2020), https://www.longtermscorecard.com/databystate/state?state=IN (choose "Indiana Fact Sheet"). Discrepancies continue as the pandemic ebbs. Although "all the facility-based care industries lost employment in both Indiana and the United States, . . . the loss was greater for the state, with continuing care retirement facilities and nursing care facilities shedding more than 10% of jobs in [a] five-quarter period." Riley Zipper, *Trends in the Elder Care Workforce in Indiana: Evidence for a Shift to Home-Based Elder Care?*, 97 IND. BUSINESS REV. 2 (Summer 2022), https://ibrc.indiana.edu/ibr/summer/article1.html.

C. Indiana nursing facility residents often have no recourse other than Section 1983 to enforce their rights.

Holding county-owned nursing facilities accountable for providing a minimum standard of care has proven difficult. Despite the receipt of enhanced Medicaid payments, counties are unaccountable for how the money is spent. Neither the federal government nor Indiana law requires nursing homes to account for how enhanced payments are allocated.

Indeed, IDOH's failure to intervene earlier in Mr. Talevski's situation demonstrates the State's willingness to let nursing homes operate with little oversight. Mr. Talevski's daughter filed an IDOH complaint against VCR around the last week of September 2016, when she discovered VCR's physician had ordered a cocktail of six psychotropic drugs for Mr. Talevski's routine use. Pet. App. 17a. Ms. Talevski's discovery came around the time she noted a steep and, until then, inexplicable decline in her father's health, including increased lethargy and the inability to feed himself and communicate in English. *Id*.

In late November 2016, VCR transferred Mr. Talevski to a neuropsychiatric hospital more than an hour away for twenty-two days. *Id*. Four days after his return, VCR sent him back to the neuropsychiatric hospital for a 10-day stay. *Id*. The day after he returned to VCR, the nursing facility sent him to the neuropsychiatric hospital for another 10-day stay. *Id*. During that third stay, VCR did not send Mr. Talevski with his dentures, which caused such damage to his gums that he could not be fitted for new ones. *Id*. at 80a. On the day Mr. Talevski was to return to VCR, January 9, 2017, it refused to readmit him. *Id*. at 18a. VCR instead attempted to send Mr. Talevski to a nursing facility in Indianapolis, located more than two hours from his family. *Id*. Mr. Talevski's family filed an involuntary transfer appeal with IDOH. *Id*.

Petitioners claim Mr. Talevski's maltreatment by VCR was successfully addressed through the administrative hearing. Pet. Merits Br. at 35. Petitioners' claim is patently untrue. The administrative law judge (ALJ) ruled in Mr. Talevski's favor and, eventually, Mr. Talevski was invited to return to VCR. *Id*. However, such a "victory" is hollow; Mr. Talevski merely

received an order to return to the nursing facility that violated his rights and neglected his needs.

Moreover, Petitioners' narrative utterly omits that VCR initially refused to comply with the administrative order and permit Mr. Talevski's return. VCR's refusal continued for weeks, despite his daughter repeatedly notifying IDOH officials about VCR's refusal to heed the order. Only after she informed her Congressman of Mr. Talevski's situation and the Congressman made a formal inquiry did VCR relent. By that time, Mr. Talevski had been residing for months in a different nursing facility, the only concern being its distance from Mr. Talevski's family.

Petitioners also miss the point when they muse that "[i]t is difficult to see how adding a damages remedy on top of the administrative procedures that [Mr. Talevski] successfully invoked would accomplish anything except pad the coffers of plaintiffs and their lawyers." Resp. Merits Br. at 35. Monetary recovery was not the Talevskis' objective. Instead, Mr. Talevski's federal court claim was filed to obtain systemic remedies, such as an order enjoining VCR and other HHC-owned nursing facilities from chemically restraining and abandoning their residents.

ALJs presiding over FNHRA hearings generally lack the authority to address systemic rights violations. Each case is limited to a single petitioner's circumstances; there is no opportunity to recognize a class of nursing facility residents through administrative hearing procedures. Further, the subject matter of FNHRA hearings is limited, in discrete terms, by federal regulation. Hearing officers may address: "(a) Any matter described in § 431.220(a)(1) for which an individual requests a fair hearing. (b) A decision by skilled nursing facility or nursing facility to transfer

or discharge a resident; and (c) A State determination with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act." 42 C.F.R. § 431.241. Thus, administrative hearings to address FNHRA violations are limited to determinations, claim denials, undue delay, involuntary transfer or discharge from a nursing facility. *Id*.; s*ee also* 42 C.F.R. § 431.220(a). There is no administrative mechanism allowing nursing facility residents to ask an ALJ to address other FNHRA rights violations, like chemical restraint; being forced to get out of bed at 5 A.M. because short-staffing means it takes staff five hours to get residents up each morning; being given an old wheelchair so the nursing facility can scrimp by not purchasing new durable medical equipment; being forced to use a mechanical lift for transfers, despite the fact that the sling used with the lift causes intense pain; or being coerced into wearing adult diapers because it is more convenient for nursing facility staff than assisting residents to the restroom. These issues are not hypothetical but instead represent anecdotes that Hoosier nursing facility residents have shared with IDR.

Nursing home residents can file a grievance pursuant to FNHRA, but this action merely triggers IDOH to conduct another facility survey. *See* 42 U.S.C. § 1396r(g)(4)(A); *see also* Ind. Code § 16-28-4-2. Often IDOH responds to substantiated rights violations by asking the nursing facility to comply with a plan of correction. *See* Ind. Code § 16-28-5-2(3). In addition to requesting corrective action from a noncompliant nursing facility, the IDOH Commissioner may impose remedies, such as a fine or licensure revocation. *See* 42 U.S.C. § 1396r(h)(1)(B); *see also* Ind. Code §§ 16-28-5-2 and 16-28-5-4.

States are required to include a set of specified remedies, such as payment and civil penalties, by state statute or regulation. *See* 42 U.S.C. § 1396r(h)(2)(A). Indiana's incorporation of the specified remedies puts careful limits on their use. For example, if a nursing facility is found to have committed "an offense," the most egregious violation category, IDOH must order immediate corrective action and "[i]mpos[e] a fine not to exceed ten thousand dollars ($10,000) or suspension of new admissions to the health facility for a period not to exceed forty-five (45) days, or both." Ind. Code §§ 16-28-5-4(a)(1) and (b)(1)-(2). Even then, once the nursing facility takes corrective action, the IDOH "[C]ommissioner may waive not more than fifty percent (50%) of the fine imposed and reduce the number of days for suspension of new admissions by one-half (1/2)." *Id*. at § 16-28-5-4(c). To impose a remedy regarding "an omission of care," the IDOH Commissioner must also obtain the concurrence of a licensed physician. *Id*. at § 16-28-5-4(d). The suggestion that a Medicaid beneficiary could convince IDOH to impose a punitive, monetary penalty on a nursing home would be laughable if it were not so miserable; recall that, in the instant case, IDOH was loath to even enforce an order from its own ALJ.

Mr. Talevski was fortunate that his daughter, an attorney, thought to file a Section 1983 suit to enforce his rights. Generally, nursing home residents and their counsel approach Medicaid-related rights violations through medical malpractice actions. However, this option is difficult, if not impossible, to execute in Indiana. A plaintiff cannot file a complaint directly in court; unless both parties agree or the case is valued at less than $15,000, medical malpractice claims must survive a medical review panel before a judge can hear the case. *See* Ind. Code §§ 34-18-8-4 through 34-18-8-

6(a). Medical review panelists consider relevant evidence, which "may consist of medical charts, x-rays, lab tests, excerpts of treatises, depositions of witnesses including parties, and any other form of evidence allowable . . . ." Id. at § 34-18-10-17(b). As such, plaintiffs are often required to hire experts and expend significant sums on depositions before they find out whether they will be permitted to get their day in court.

Unlike many other medical malpractice acts that capitate the amount of damages a plaintiff can recover in a medical malpractice action, "[t]he total amount recoverable for an injury or death of a patient may not exceed" $1.8 million in Indiana. Ind. Code § 34-18-14-3(a). That is, Indiana limit applies not just to the sum of damages a plaintiff receives for their death or injury, but also includes any additional damages, such as pain-and-suffering. Indiana statute also limits the amount of attorney's fees that can be recovered in a medical malpractice claim. *See* Ind. Code § 34-18-18-1 *et seq*.

The limited and uncertain nature of recovery available through Indiana's Medical Malpractice Act, coupled with procedures that require significant money to be spent before a plaintiff knows whether she will get to court, pragmatically means that few Indiana attorneys are willing to take nursing facility medical malpractice cases unless there is significant injury or death. This leaves people with claims for rights violations where there is not significant monetary damages unlikely to find legal representation.

On the other hand, as Petitioners note, Section 1983 suits offer plaintiffs "access to tangible benefits – such as policy change or injunctive relief, damages, attorneys fees, and costs – that are unavailable under FNHRA," Pet. Merits Br. at 41, and Indiana's Medical Malpractice Act. Indeed, a reasonable likelihood that

attorneys will receive compensation for their time and resources. A public service attorney could feasibly represent an indigent client, such as a Medicaid recipient living in a nursing facility, in a Section 1983 claim. The opportunity to obtain broader remedies – whether monetary damages or injunctive relief – also makes it more palatable for the beneficiary to repeatedly revisit the rights violations they suffered; often, as in the instant case, people with disabilities bring civil rights cases because they do not want others to endure what they have experienced.

Neither administrative actions under FNHRA nor medical malpractice claims singularly cover the spectrum of complaints likely to arise or relief needed. The only avenue for a nursing facility resident and their attorney to receive both an avenue for redress and ability to recover attorney's fees in Indiana is to pursue their claim using Section 1983.

II. The private right of action is critical to Spending Clause Operations and Enforcement.

A. State administrative enforcement mechanisms are inadequate to address programmatic rights violations.

Petitioners assert that "plainly, the remedies available under FNHRA are more than sufficiently comprehensive to foreclose resort to Section 1983." Pet. Merits Br. at 38. Yet, this claim is untrue, applied both to the facts of the instant case and, more broadly, to other nursing home residents. Even beyond FNHRA, the default administrative enforcement tools in most Spending Clause statutes are ineffective in upholding beneficiary rights.

FNHRA designates specific administrative mechanisms to address statutory violations. For example, each nursing facility is required to be annually surveyed by the state. *See* 42 U.S.C. § 1396r(g)(2)(A). If statutory violations are substantiated, the state or federal government may impose a fine, deny payment, install temporary management at the facility, transfer facility residents, terminate the facility's Medicaid participation, and/or close the facility. *See* 42 U.S.C. § 1396r(h)(2)(A). Additionally, FNHRA mandates that each nursing facility maintain a grievance procedure, *see* 42 U.S.C. § 1396r(c)(1)(A)(vi), and that States grant individual residents the opportunity to bring appeals regarding involuntary transfers and discharges from the facility in which they reside. *See* 42 U.S.C. § 1396r(e)(3).

Nonetheless, these administrative measures are "not . . . anything close to the type of 'unusually elaborate, carefully tailored, and restrictive enforcement schemes' that section 1983 claims would frustrate." *Talevski ex rel. Talevski v. Health & Hosp. Corp. of Marion Cnty.*, 6 F.4th 713, 720 (7th Cir. 2021). FNHRA's administrative mechanisms "are designed only to ensure facilities' compliance with FNHRA's various standards. They do not address, and thus do not protect, individual entitlements to be free from chemical restraints or involuntary transfer or discharge," *id*. at 721, just as they neither address nor protect other promises within the Residents' Bill of Rights.

Quite simply – as demonstrated in the instant case – FNHRA's administrative measures provided no relief to Mr. Talevski, nor to other similarly-treated VCR residents. His administrative hearing resulted in a paper tiger; the ALJ ordered his return to VCR, but IDOH refused to enforce the order for months. The

administrative complaints filed by Mr. Talevski's daughter initially resulted in IDOH's decision not to substantiate the claims therein. It was only after she repeatedly demanded that IDOH send its best surveyor to re-evaluate VCR that the agency substantiated that VCR violated Mr. Talevski's rights. These outcomes would make Thrasymachus proud; they illustrate a system in which justice is whatever is in the interest of the stronger. On the other hand, civil rights leaders are rolling over in their graves.

Even if one assumes that other States are more attentive to nursing facility rights violations than their Hoosier counterparts, FNHRA's administrative mechanisms are still insufficient. Assume the ALJ read his charge broadly, and agreed to address not only Mr. Talevski's involuntary transfer from VCR, but also his chemical restraints and the harm caused by the absence of his dentures during a transfer. Let us also assume that the state agency regulating nursing facilities enforces the administrative order, arranging for Mr. Talevski's quick return to VCR. Even under these most favorable circumstances, Mr. Talevski merely gets returned to the nursing facility that violated his rights in the first place. The State could fine the nursing facility for its violations, but the Talevskis would receive nothing for the disfigurement of Mr. Talevski's mouth; the function Mr. Talevski permanently lost as a result of overmedication, including the ability to communicate in English; the mileage costs incurred each time VCR transferred Mr. Talevski to stay at the neuropsychiatric hospital; nor the time and effort involved in filing complaints and preparing for and participating in administrative hearing. The State could take over management of the facility, close it for new admissions, or shut it down entirely. However, these remedies do not help the Talevskis

either. There is no guarantee that new management would perform better than their predecessors, nor a guarantee that systemic changes implemented by new management would continue beyond their limited tenure. The latter remedies may shield future residents from rights violations at VCR, but many would presumably be placed at a facility farther from their community. Shutting down the facility would upend the lives of all residents at the facility. The State cannot, for example, impose a comprehensive consent decree upon VCR, requiring its compliance with specific FNHRA provisions and appointing a special monitor to ensure compliance over a multi-year period. But a federal court could order such a remedy under Section 1983 proceedings.

Similarly, FNHRA remedies available to the Secretary of the U.S. Department of Health and Human Services fail to provide adequate recourse to nursing facility residents whose rights have been violated. For State- and municipally-owned nursing facilities, "the Secretary shall have the authority and duties of a State under this subsection, including the authority to issue remedies described in clauses (i), (ii), and (iii) of paragraph (2)(A)." 42 U.S.C. § 1396r(h)(3)(A). For the same reasons those administrative mechanisms are ineffective at the state level, they are ineffective when applied by the federal government.

In addition to its inadequate remedies for nursing facility residents, FNHRA's administrative remedies presuppose the existence of a strong infrastructure that is often absent in reality. IDOH's ability to assess quality and safety in nursing facilities is dependent upon thorough, intelligent surveyors. The job mandates that the employee be a registered nurse, yet the full-time salary begins at just $47,476 per year. *See*

Work for Indiana: Long Term Care Nurse Surveyor, IN.GOV CAREERS (Aug. 25, 2022), https://workforindiana.in.gov/job/Muncie-Long-Term-Care-Nurse-Surveyor-IN-47302/903269500/. Ball Memorial Hospital, located in the same Hoosier city as the State's recent surveyor job posting, is currently hiring more than ten registered nurses for full-time positions, at a rate of between $27 and $47 per hour. *See* Indeed, *Registered Nurse – (RN) – IU Health Ball Memorial Hospital* (accessed Sept. 12, 2022), https://www.indeed.com/jobs?q=nurse+rn&l=Muncie%2C+IN&vjk=9330adaf71519bcc&advn=2355618261919471. These figures suggest that a nurse just beginning their career would earn approximately $10,000 less per year as a state surveyor than working in a hospital. This pay differential is likely exacerbated as a nurse acquires more experience. In a state with a recognized "severe nursing shortage," where there are approximately 4,300 positions currently open and in need of a nurse to fill, *see* Tim McNicholas, *New Indiana Law Aims to Address Nursing Shortage*, CBS NEWS CHICAGO (July 1, 2022), https://www.cbsnews.com/chicago/news/new-law-aims-to-address-states-nursing-shortage/, there are not enough surveyors to provide consistent, quality, and timely oversight.

There is a similar dearth of ALJs with relevant expertise in FNHRA matters. Most administrative law adjudication proceedings in Indiana have been consolidated to the Office of Administrative Law Proceedings (OALP). *See* Ind. Code §§ 4-15-10.5-7 and 4-15-10.5-12. "OALP assigns Administrative Law Judges to preside over proceedings involving dozens of State Agencies." *See* OALP, *Welcome to the Office of Administrative Law Proceedings*, IN.GOV (accessed Sept. 13, 2022), https://www.in.gov/oalp. A review of the OALP's staff chart reveals the agency has a total of thirty-three

ALJs. *See Find a Person*, IN.GOV (accessed Sept. 13, 2022), https://www.in.gov/apps/iot/find-a-person/ (search for employees from the "Office of Administrative Law Proceedings," and review three pages of search results). Relevantly, not all of these ALJs earned law degrees, meaning they may not be assigned to cases where that credential is required of the hearing officer. *See* Ind. Code § 4-15-10.5-15(b). Availability is further limited by the fact that not all thirty-three ALJs work full-time; several maintain a solo practice and work as contractors for OALP. Thirty-three ALJs to preside over nearly the entirety of the State's administrative law adjudications is insufficient; IDR has routinely received hearing decisions from OALP ALJs that are more than a month overdue pursuant to the statutory timeline.

National demographic trends will further exacerbate oversight demands and staff shortages. "In 2019, there were 54.1 million people age 65 and older . . . . The population is projected to reach 80.8 million by 2040 and 97.4 million by 2060." Administration on Community Living, *Projected Future Growth of Older Population*, U.S. DEPT. OF HEALTH AND HUMAN SVCS. (updated May 4, 2022), https://acl.gov/aging-and-disability-in-america/data-and-research/projected-future-growth-older-population. Each day, 10,000 people celebrate their 65th birthday. *See* Alexandra Moe, *The Crisis Facing Nursing Homes, Assisted Living and Home Care for America's Elderly*, POLITICO (July 28, 2022), https://www.politico.com/news/magazine/2022/07/28/elder-care-worker-shortage-immigration-crisis-00047454. At the same time, birth rates are declining. *Id*. These trends have created a caregiver shortage. *Id*. The shortage will become increasingly dire for the country's seniors and people with disabilities; the Bureau of Labor Statistics anticipates that demand for

home health and personal care workers – which is currently the fastest-growing career in the country – will increase 33% in the next ten years. *Id*. As such, more administrative oversight will be necessary in the coming years although there is insufficient oversight now. Section 1983 offers vulnerable populations an alternative to having to bide their time indefinitely waiting in an administrative queue while their rights are being violated.

B. A private right of action in federal court serves as a mechanism within the U.S.'s foundational checks and balances system.

Petitioners' *amici* States claim that Section 1983 violates political accountability. States' *Amici* Merits Br. at 19. They argue that "[b]oth state and federal governments, as politically accountable parties to a contract, must be able to make their own decisions over whether and how to enforce the terms of the deal . . . ." *Id*. at 20. Nonetheless, as Section IB, *supra*, alludes, political accountability is largely a myth.

Individual States can receive billions of dollars from the federal government to cooperate in the administration of individual Spending Clause programs. *See Annual Medicaid & CHIP Expenditures*, U.S. DEPT. HEALTH AND HUMAN SVCS. (accessed Sept. 13, 2022), https://www.medicaid.gov/state-overviews/scorecard/annual-medicaid-chip-expenditures/index.html. "Medicaid account[ed] for 7% of total federal outlays in [Fiscal Year] 2020" and is "the largest source of federal revenues for state budgets." Robin Rudowitz et al., *Medicaid Financing: The Basics*, HENRY J. KAISER FAMILY FOUNDATION (May 7, 2021), https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/. Yet, the vast size of these programs requires a

proportionate number of managers. These bureaucrats comprise what some call the fourth branch of American government. *See* Jonathan Turley, *The Rise of the Fourth Branch of Government*, WASHINGTON POST (May 24, 2013), https://www.washingtonpost.com/opinions/the-rise-of-the-fourth-branch-of-government/2013/05/24/c7faaaa0-c2ed-11e2-9fe2-6ee52d0eb7c1_story.html. Although the governor may appoint the head of a state agency, bureaucrats are not elected officials and lack any political accountability. Therefore, the *amici* States cannot genuinely suggest that FNHRA's remedies, which are heavily dependent on the decisions of autonomous bureaucrats, perpetuate government accountability.

Indiana's administrative adjudication process, and subsequent opportunity for judicial review, has notable critics, including state Supreme Court Justice Geoffrey Slaughter. He recently questioned the legality of Indiana's Administrative Orders and Procedures Act (AOPA):

> I write separately to note my deep concerns with prevailing administrative law as codified in AOPA and interpreted by our courts. Under the current system, a government agency both finds the facts and interprets the statutes that supply the rules of the decision, and the courts' only role (as we have interpreted AOPA) is to defer to all aspects of the agency's decision-making. Neither judge nor jury finds facts. And no court gives a fresh, plenary interpretation as to the agency's determination of law or to its application of law to the facts.
>
> In a future case, where the issues are raised and the arguments developed, I am open to entertaining legal challenges to the system

> for adjudicating the legal disputes that our legislature assigns agencies to resolve in the first instance, subject only to a highly circumscribed right of judicial review as set forth in AOPA.

Ind. Dept. of Nat. Res. v. Prosser, 139 N.E.3d 702, 702-703 (Ind. 2020) (concurring opinion). Justice Slaughter's concerns are relevant to the instant case.

Petitioners maintain that Section 1983 is unnecessary and those adversely affected by municipally-operated nursing facilities (and, pursuant to the breadth of the questions presented in the instant case, any individual aggrieved by a State action in a program passed via the Spending Clause) can use the administrative measures established in FNHRA (or whatever other measures Congress articulated in Spending Clause program statutes). *See* Pet. Merits Br. at 38-40. Yet, there is an inherent conflict of interest between the ALJ's required deference to the agency taking the adverse action and their role as an impartial fact-finder. Consider, for example, that OALP's Code of Judicial Conduct states that "[ALJs] may recommend to an ultimate authority that ambiguous policies or rules be clarified to promote ease of interpretation and application; however, an [ALJ] shall afford deference to the ultimate authority's published rules or policies unless doing so is contrary to law." 41 Ind. Admin. Code § 1-2-2. Incredibly, IDR has participated in hearings during which ALJs stated their role was not to consider whether an agency action is contrary to federal law, but only state law, as they are state employees.

Generally, an appellee's only means of remedying an incorrect decision by an ALJ is to seek agency review. *See* Ind. Code §§ 4-21.5-3-29 and 4-21.5-5-2(c). During

that process, the "ultimate authority" of the agency taking the initial adverse action against the appellee "shall issue a final order: (1) affirming; (2) modifying; or (3) dissolving the administrative law judge's order." Ind. Code § 4-21.5-3-29(c). Thus, even if an ALJ agreed a state agency violated an individual's rights, the agency can appeal to themselves as the ultimate authority to get the decision reversed in its favor.

Judicial review is the next opportunity for the individual to seek relief. *See* Ind. Code § 4-21.5-5-3(a). As Justice Slaughter notes, though, during judicial review, courts are quite deferential to the agency. *See Ind. Dept. of Nat. Res.*, 139 N.E.3d at 702-703. Courts "do not try the case de novo and do not substitute [their] judgment for that of the agency." *Miami Cnty. v. Ind. Dept. of Nat. Res.*, 146 N.E.3d 1027, 1030 (Ind. Ct. App. 2020) (quoting *Walker v. State Bd. of Dentistry*, 5 N.E.3d 445, 448 (Ind. Ct. App. 2014)). Given that the agency can rule in its favor during agency review, the individual almost always bears the burden of proof. *See id.*; *see also* Ind. Code § 4-21.5-5-14(a). Pragmatically, going through the administrative and judicial review processes takes considerable time. Indeed, Mr. Talevski has passed away, but it will be years from now before a final decision is rendered in a matter that developed in 2016. In sum, the likelihood that a Hoosier can meaningfully and timely vindicate their FNHRA rights through the administrative hearing process is unpromising.

In contrast, Section 1983 allows individuals to pursue their claims in federal court. Unlike state courts, that traditionally deal with criminal, probate, and other routine matters, federal courts are better equipped with the necessary expertise to address rights violations and constitutional issues. *See Comparing*

Federal & State Courts, U.S. COURTS (accessed Sept. 14, 2022), https://www.uscourts.gov/about-federal-courts/court-role-and-structure/comparing-federal-state-courts. The expertise of federal judges provides an important counterbalance to the expertise of the State agency taking adverse action against the individual.

Additionally, across the country, state court judges get hired through a variety of mechanisms, including elections and appointments by elected officials. *Id*. Some state court judges have a lifetime tenure, while others serve for discrete terms. *Id*. Federal judges, in contrast, are nominated by the President (i.e., the executive branch) and confirmed by the Senate (i.e., the legislative branch). *Id*. Although federal judges can be removed from office through impeachment proceedings, their tenure is generally for life. *Id*. The federal judiciary system, then, ensures that judges are highly scrutinized for competency and fairness. Lifetime tenure enables them to make unpopular decisions without fear of penalty. State judges, on the other hand, may lack these characteristics. For these reasons, too, Section 1983 proceedings are part of an important checks-and-balances system.

The *amici* States suggest the right to pursue legal action through Section 1983 "denies the States the opportunity to decide whether to carry out a state program without some (or all) of the federal financial assistance that might otherwise be available." *Amici* States Merit Br. at 27. That is, the States argue that they should be permitted to pick and choose which pieces of comprehensive federal programs they follow and accept a fine for those pieces of a program they reject. But there are several problems with this argument.

First, political accountability assumes that citizens are active and engaged in politics. Nonetheless, the

beneficiaries of many Spending Clause programs – including the aged, the disabled, and children – may lack the means or ability to hold state and federal officials accountable for their platforms. People with mental illness, including individuals residing in mental health institutions and those with cognitive disabilities like dementia, are prohibited from voting in certain states. *See* Charles P. Sabatino, *Guardianship and the Right to Vote*, 45 HUMAN RIGHTS 3 (June 25, 2020), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/voting-in-2020/guardianship-and-the-right-to-vote/. Individuals under guardianship may also be disenfranchised, whether due to state statute or an individual guardian's decision. *Id*. Foster care children under the age of 18 also lack the right to vote. Even if people with disabilities maintain the ability to vote, they must successfully navigate barriers such as finding reliable, accessible transportation to a polling place or navigating a webpage to timely request an absentee ballot. In short, vulnerable populations lack a dependable and accessible means of holding political officials accountable.

Second, the *amici* States assume that political choices are deliberate. The States provide an example in which they claim that a State should be permitted to decide that its Medicaid plan will not fund abortion-related services, consistent with the will of its majority pro-life citizenry. *Id*. This example suggests that elected officials should have authority to weigh the advantages and disadvantages of complying with federal regulations that are opposed by the majority of voters. Pursuant to this logic, voters will hold State officials accountable when policy decisions that oppose the will of the majority are implemented. However, the States' assumed responsivity of the electorate and deliberative nature of government-related decisions

exists largely in theory rather than reality. Many Spending Clause programs are so large that violations of federal regulations occur without a conscious decision-making process. Presumably, few would favor State-sanctioned chemical restraint of nursing facility residents. Nonetheless, given the number of nursing facilities in Indiana and the absence of thorough oversight, this rights violation is not unprecedented. Relatedly, voters are often completely unaware of these rights violations unless they or a loved one is directly affected. The arcane nature of Medicaid regulations, in particular, renders the subject matter inaccessible to many voters that may otherwise want to hold the State accountable. Hence, the amici States' assumptions would permit officials with busy agendas could continue dropping the proverbial ball and ignore complex programmatic issues.

Section 1983 is a critical tool for Spending Clause program beneficiaries to hold States accountable for rights violations. The ballot box is not a comparable tool. Should the Court abrogate beneficiaries' ability to use the federal judiciary as a check on State power, it will facilitate States' underlying tendency to disregard the needs of the most vulnerable.

CONCLUSION

For the foregoing reasons, IDR, as *amicus curiae*, respectfully ask the Court to affirm the Seventh Circuit's decision.

Respectfully submitted,

MELISSA L. KEYES
Executive Director
THOMAS E. CRISHON
Legal Director
EMILY A. MUNSON
Policy Director
Counsel of Record
INDIANA DISABILITY RIGHTS
4755 Kingsway Drive
Ste. 100
Indianapolis, IN 46205
(317) 504-2578
EMunson1@
IndianaDisabilityRights.org

Counsel for Amici Curiae

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