No. 20-1664

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

GORGI TALEVSKI, by next friend IVANKA TALEVSKI,
Plaintiff-Appellant

v.

HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY, et al.,
Defendants-Appellees

Appeal from the United States District Court
for the Northern District of Indiana

No. 2:19-cv-00013
Hon. James T. Moody, District Judge, presiding

UNOPPOSED MOTION OF INDIANA HEALTH CARE ASSOCIATION, ILLINOIS HEALTH CARE ASSOCIATION, AND WISCONSIN HEALTH CARE ASSOCIATION, INC. FOR LEAVE TO FILE BRIEF AMICUS CURIAE

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Indiana Health Care Association, Illinois Health Care Association, and Wisconsin Health Care Association, Inc., by their counsel, Quarles & Brady LLP, move, pursuant to Fed. R. App. P. Rule 29, for leave to file a brief amicus curiae. The proposed brief accompanies this motion.

INTERESTS OF THE AMICI CURIAE

The Indiana Health Care Association

The Indiana Health Care Association (InHCA) is a trade association whose members provide long-term care services and support to more than 28,000 of Indiana's geriatric, developmentally disabled, and other vulnerable citizens. It is Indiana's largest trade association and advocate. It represents proprietary, not-for-profit, and hospital-based skilled nursing facilities, assisted living communities, and independent living facilities. InHCA's more than 450 member facilities provide over 10 million patient days of care per year. The majority of patients served by InHCA member facilities are Medicare or Medicaid recipients. Government-provided health care reimbursements make up around 80% of the member facilities' reimbursement for long-term care services and supports.

The Illinois Health Care Association

The Illinois Health Care Association (IHCA) was founded in 1950 and represents more than 500 licensed and certified long-term care facilities and programs for the developmentally disabled throughout Illinois. Its mission as a non-profit organization is to lead in advocacy and education for its members: proprietary and non-proprietary facilities that provide multiple levels of care, including skilled,

intermediate, developmentally and intellectually disabled, skilled pediatric, assisted living and sheltered. In carrying out that mission, IHCA seeks to promote the highest standard of services in facilities and programs for Illinois' senior citizens and others facing physical and mental challenges in Illinois.

The Wisconsin Health Care Association

Founded in 1951, the Wisconsin Health Care Association, Inc. (WHCA) is a non-profit organization dedicated to representing Wisconsin's long-term and post-acute care providers and the vulnerable residents they serve. The Wisconsin Center for Assisted Living (WiCAL) is a division of WHCA that advocates for assisted living facilities by helping its members provide the highest quality services to the Badger State's most vulnerable senior citizens. Together, WHCA and WiCAL represent 190 skilled nursing facilities and 228 assisted living centers in Wisconsin.

†

The Health Care Associations share a common interest in this proceeding because their members are engaged in the daily business of caring for nursing facility residents like the plaintiff in this case, Mr. Talevski, and have firsthand experience with the extensive state and federal regulatory regimes already in place to protect and promote residents' well-being. That makes the Associations uniquely qualified to describe this regulatory landscape to the Court—and to explain why a new federal right of action is not only unnecessary, but would in fact harm nursing facility residents by further diverting scarce resources away from resident care. Accordingly, the Associations request leave to file the accompanying brief, and are authorized to state that counsel for the parties do not oppose this motion.

Respectfully submitted,

/s/ James E. Goldschmidt

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VERIFIED STATEMENT IN SUPPORT OF UNOPPOSED MOTION FOR LEAVE TO FILE BRIEF OF AMICUS CURIAE

Under 28 U.S.C. § 1746, I, James E. Goldschmidt, counsel for movants, verify that I have reviewed the statements of fact in the accompanying Unopposed Motion for Leave to File Brief of Amicus Curiae and state that they are true and correct.

/s/ James E. Goldschmidt

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**CERTIFICATE OF COMPLIANCE
WITH TYPE-VOLUME LIMIT**

This motion complies with the type-volume limit of Fed. R. App. P. 27(d)(2)(A) because this motion contains 473 words.

As required by Fed. R. App. P. 27(d)(1)(E), this motion complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because this motion has been prepared in a proportionally-spaced typeface using Century Schoolbook in 12-point font, with 11-point font in footnotes.

Dated: October 6, 2020.

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CERTIFICATE OF SERVICE

Certificate of Service When All Case Participants Are CM/ECF Participants

I hereby certify that on October 6, 2020, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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BRIEF OF AMICI CURIAE
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CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No.: 20-1664

Short Caption: *Talevski v. Health and Hospital Corporation of Marion County*

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):

Indiana Health Care Association
Illinois Health Care Association
Wisconsin Health Care Association, Inc.

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Quarles & Brady, LLP

(3) If the party or amicus is a corporation:

Identify all its parent corporations, if any; and

None

list any publicly held company that owns 10% or more of the party's or amicus' stock:

None

Respectfully submitted this 6th day of October, 2020.

s/ E. King Poor
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Please indicate if you are *Counsel of Record* for the above-listed parties pursuant to Circuit Rule 3(d). **Yes** ___ **No** X

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None

Respectfully submitted this 6th day of October, 2020.

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None

Respectfully submitted this 6th day of October, 2020.

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Please indicate if you are *Counsel of Record* for the above-listed parties pursuant to Circuit Rule 3(d). **Yes** __ **No** X

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The Indiana Health Care Association, Illinois Health Care Association, and Wisconsin Health Care Association, Inc. (together, the "Health Care Associations") submit this amicus brief in support of affirming the decision of the district court.[1]

INTERESTS OF THE AMICI CURIAE

The Indiana Health Care Association

The Indiana Health Care Association (InHCA) is a trade association whose members provide long-term care services and support to more than 28,000 of Indiana's geriatric, developmentally disabled, and other vulnerable citizens. It is Indiana's largest trade association and advocate. It represents proprietary, not-for-profit, and hospital-based skilled nursing facilities, assisted living communities, and independent living facilities. InHCA's more than 450 member facilities provide over 10 million patient days of care per year. The majority of patients served by InHCA member facilities are Medicare or Medicaid recipients. Government-provided health care reimbursements make up around 80% of the member facilities' reimbursement for long-term care services and supports.

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[1] Under Fed. R. App. P. 29(a)(4)(e), counsel for the amici state that they have authored this brief in its entirety. No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than amici, their members, or their counsel have made a monetary contribution to its preparation or submission. A motion for leave to file this brief under Fed. R. App. P. 29(a)(2) has been filed separately.

profit organization is to lead in advocacy and education for its members: proprietary and non-proprietary facilities that provide multiple levels of care, including skilled, intermediate, developmentally and intellectually disabled, skilled pediatric, assisted living and sheltered. In carrying out that mission, IHCA seeks to promote the highest standard of services in facilities and programs for Illinois' senior citizens and others facing physical and mental challenges in Illinois.

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The Health Care Associations share a common interest in this proceeding because their members are engaged in the daily business of caring for nursing facility residents like the plaintiff in this case, Mr. Talevski, and have firsthand experience with the extensive state and federal regulatory regimes already in place to protect and promote residents' well-being. That makes the Associations uniquely qualified to describe this regulatory landscape to the Court—and to explain why a new federal right of action is not only unnecessary, but would in fact harm nursing facility residents by further diverting scarce resources away from resident care.

SUMMARY OF THE ARGUMENT

A major premise of Talevski's whole argument is that nursing facility residents need a right of action under 42 U.S.C. § 1983 because they are not adequately protected under existing administrative and judicial regimes.[2]

That premise is entirely incorrect. Administrative oversight of nursing facilities is robust at both the state and the federal level, and these regulatory tools are supplemented by existing judicial remedies in the state and federal courts. The amici will explain the regulatory framework and provide concrete examples of state and federal enforcement specifically targeting quality of care.

Given the comprehensive regulatory regime already in place, a new right of action under § 1983 is not necessary to protect residents' rights. Instead, it would do exactly what the *Blessing*[3] court warned against—"strain judicial competence"—while at the same time diverting already overburdened nursing facility resources away from resident care. In short, transforming every complaint about nursing home care into a potential federal civil rights case would add needless layers of expense, complexity, and distraction, all of which would thwart—not promote—Talevski's professed goal of improving resident care.

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[2] *See* Talevski Br. at 8–10 (complaining about "FNHRA's inadequate public enforcement mechanisms"); *id.* at 22–23 (asserting, as fact, that "public enforcement mechanisms have failed to protect nursing home residents from widespread abuse," that inability to pursue § 1983 claims under FNHRA "has led to the same underenforcement problems that caused Congress to enact the FNHRA in the first place," and that state regulation "fail[s] to ensure that nursing home residents receive a minimum standard of care").

[3] *Blessing v. Freestone*, 520 U.S. 329, 341, 117 S.Ct. 1353, 137 L.Ed.2d 569 (1997).

ARGUMENT

I. Existing state and federal law already provide extensive regulation and remedies addressing nursing facility care.

A. Administrative regulation and remedies under state law

As the Court considers whether to create a new cause of action for nursing home residents in the federal courts of this circuit, it may wish to consider what Illinois, Indiana, and Wisconsin are already doing to regulate nursing facilities and promote the well-being of residents in their care. *See Matthews v. Rodgers*, 284 U.S. 521, 525, 52 S.Ct. 217, 76 L.Ed. 447 (1932) (emphasizing "[t]he scrupulous regard for the rightful independence of state governments which should at all times actuate the federal courts").

1. Illinois

Illinois facilities are regulated by the Illinois Department of Public Health, which enforces the Illinois Nursing Home Care Act (210 ILCS 45) (the "Act") and the Department's administrative rules for a variety of licensed facilities (77 Ill. Admin. Code §§ 300.110–390.3330).

The bipartisan Nursing Home Care Act of 1979, which became law on March 1, 1980 (the "1979 Act"), addressed many of the problems uncovered by a Legislative Investigating Commission under a previous version of the Act in existence since 1945 (the "1945 Act"), repealing the 1945 Act and providing a completely new set of regulations in an effort to protect and assure quality health care for individuals residing in Illinois' nursing facilities.

The 1979 Act emphasized four major areas not covered in the 1945 Act. First, it set out a Bill of Rights for residents and spelled out the facilities' responsibilities. *See* 210 ILCS 45/2-101 through 2-113. Second, it expanded the enforcement powers of state agencies regulating long-term care, particularly the Department. Third, it specified minimum qualifications and training for nurses' aides, orderlies, and nurse technicians. Fourth, it offered relatives, friends, and concerned community members the opportunity to become involved in promoting and monitoring the delivery of quality care to Illinois residents.

Unlike the Federal Nursing Home Reform Act of 1987 ("FNHRA"), 42 U.S.C. § 1396r, and as detailed in a March 1980 *Illinois Bar Journal* article published by Richard M. Daley and Dean Timothy Jost,[4] the 1979 Act expressly provided a resident and their representative a private right of action to sue an owner or licensee for vicarious liability for the intentional or negligent acts or omissions of its employers or agents injuring a resident (Section 3-601), to seek treble damages and costs and attorneys' fees for a violation of a resident's rights (Section 3-602), and to bring a class action (Section 3-604). The Act retains these same protections today.

As set forth in the Daley and Jost article, the 1979 Act provided basic rights to residents, including basic constitutional rights (Section 2-101), the right to manage their own financial affairs (Section 2-102), rights to respect and privacy in their medical and personal care (Section 2-105), and the right not to be subjected to abuse or neglect (Section 2-107). Other provisions of the 1979 Act represented major

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[4] R. Daley and T. Jost, "The Nursing Home Reform Act of 1979," 68 ILL. BAR J. 448 (1980).

innovations to protect residents' rights. These included the guaranteed right of access to facilities for employees or agents of public agencies, representatives of community legal programs or members of community organizations (Section 2-110), as well as the right to contest a resident's involuntary transfer or discharge (Sections 3-401 through and including 3-413).[5]

The second major area covered by the 1979 Act was enforcement. As Daley and Jost explained, the 1979 Act provided "new boldness and aggressiveness on the part of the Department in pursuing persistent and flagrant violations of the Act." Enforcement remedies available to the Department included corrective action plans (Section 3-303); placement on a list of facilities that could not admit new residents or receive referrals from public agencies (Section 3-304); financial penalties (Section 3-305); imposition of a conditional license subject to immediate revocation (Sections 3-311 to 3-317); license suspension or revocation (Section 3-119); placement of a monitor in a facility (Section 3-501); actions for receivership (Section 3-502); actions for injunctive relief (Section 3-701); and criminal penalties (Section 3-318).

[5] Other provisions of the 1979 Act specifically addressing residents' rights included: the right to adequate storage space for personal property (Section 2-103); residents' right to be included in their plan of care and protected from experimental research (Section 2-104(a)); the right to refuse treatment (Section 2-104(b)); the right to inspect their records (Section 2-104(c)); the right to private, non-censored communication through telephone conversations, letters, and private visits (Section 2-108); the right to the free exercise of religion (Section 2-109); the right to discharge themselves voluntarily (Section 2-111); the right to present grievances without retaliation (Section 2-112); and the right to refuse to perform uncompensated labor (Section 2-113). Additionally, to protect the rights of residents and establish facility responsibility, Section 2-202 of the 1979 Act mandated that a written contract be executed between a facility and the resident.

In an early decision by the Illinois Supreme Court interpreting the 1979 Act, *Harris v. Manor Healthcare Corp.*, 111 Ill. 2d 350 (1986), the Court recognized that the General Assembly enacted the 1979 Act, "described by a principal sponsor as a 'full reform of the nursing home industry,'" "amid concerns over reports of 'inadequate, improper and degrading treatment of patients in nursing homes.'" *Id.* at 357–58 (quoting Senate Debates, 81st Ill. Gen.Assem., May 14, 1979, at 181 (statement of Sen. Richard M. Daley), 184 (statement of Sen. Karl Berning)).

The Court observed that the General Assembly had granted the Department "expanded regulatory and enforcement powers, and created civil as well as criminal penalties for violation of the Act." *Id.* at 358–59. At the same time, the Court noted that "Illinois has joined several States in giving residents a cause of action for damages against nursing home owners and operators for violations of the statute." *Id.* at 359–60 (listing Connecticut, Massachusetts, Missouri, New Jersey, New York, Ohio, Oklahoma, and West Virginia). Both of these alternatives bolstered enforcement of the "bill of rights," a "central component of the Act." *Id.* at 358.

The Department takes seriously its role under the Act. It has promulgated comprehensive regulations governing skilled nursing and intermediate care facilities (Ill. Admin. Code, Title 77, Part 300), sheltered care facilities (Part 330), veterans' homes (Part 340), intermediate care facilities for the developmentally disabled (Part 350), community living facilities (Part 370), specialized mental health rehabilitation facilities (Part 380), supportive residences (Part 385), and long-term care facilities for residents under age 22 (Part 390).

To enforce its rules and protect the residents it serves, each year the Department "conducts approximately 1,300 full, on-site licensure inspections of nursing homes and responds to approximately 6,000 complaints."[6] Using the tools provided by the Act, the Department monitors, investigates, and when warranted, issues licensure violations and fines as shown in Table 1 below:

—Table 1—

Illinois Department of Public Health
Licensure Violations and Fines, 2017–2019

Year	Violations Issued	Fines Issued	Fines
2017[7]	619	310	$3,388,955
2018[8]	571	357	$2,526,300
2019[9]	529	395	$1,956,345
Total	1,719	1,062	$7,871,600

The other major enforcement avenue under the Act, the private right of action afforded to residents and their representatives, is discussed in greater detail in Section I.C, below.

[6] Illinois Dept. of Public Health, "Who Regulates Nursing Homes?," available online at http://www.idph.state.il.us/healthca/nhregulate.htm (last visited Oct. 1, 2020).

[7] Illinois Dept. of Public Health, *Long-term Care Annual Report to the Illinois General Assembly* (July 2018) at 36, available online at http://www.dph.illinois.gov/sites/default/files/publications/publicationsohcr2018-ltc-annual-report.pdf (last visited Oct. 1, 2020).

[8] Illinois Dept. of Public Health, *Long-term Care Annual Report to the Illinois General Assembly* (July 2019) at 31, available online at https://www.ilga.gov/reports/ReportsSubmitted/510RSGAEmail1132RSGAAttach2019%20Long-Term%20Care%20Annual%20Report.pdf (last visited Oct. 1, 2020).

[9] Illinois Dept. of Public Health, *Long-term Care Annual Report to the Illinois General Assembly* (July 2020) at 30, available online at https://www.dph.illinois.gov/sites/default/files/publications/long-termcareannualreport2020.pdf (last visited Oct. 1, 2020).

2. *Indiana*

Indiana's nursing facilities are regulated by the Indiana State Department of Health, which oversees licensure (Ind. Code § 16-28-2-1 *et seq.*), investigates complaints (Ind. Code § 16-28-4-1 *et seq.*), issues citations (Ind. Code § 16-28-5-2), and identifies remedies for breaches, which may include corrective action, fines of up to $10,000, suspension of new admissions, or license revocation (Ind. Code § 16-28-5-4). The Department may also place monitors within facilities (Ind. Code § 16-28-7-1 *et seq.*). Indiana's enforcement regime includes health facility quality assessments (Ind. Code § 16-28-15-1 *et seq.*) and a hearing and appeal process culminating in judicial review (Ind. Code § 16-28-10-1 *et seq.*).

The Department has also promulgated over 100 pages of licensing and operational standards for Indiana health facilities (410 IAC 16.2). These rules were "developed in the spirit of focusing on potential and actual outcomes of care," and are "intended to focus on achieving the best practicable health and happiness of residents, and preventing systemic, adverse effects." 410 IAC 16.2-0.5-1(c). The Department enforces its rules through the Division of Long-Term Care, which (among other things) maintains a Comprehensive Care Facility Licensing and Certification Program for long-term care facilities. "Program staff conduct[ ] health and life safety code surveys and investigate[ ] complaints in order to assess the compliance of the facilities with the rules and regulations."[10]

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[10] Indiana State Dept. of Health, "Comprehensive Care Facility (Nursing Homes) Licensing and Certification Program," available online at https://www.in.gov/isdh/20511.htm (last visited Oct. 1, 2020).

3. *Wisconsin*

In Wisconsin, nursing facilities are regulated by the Department of Health Services. Like Illinois, Wisconsin has enacted a private cause of action for nursing facility residents. *See* Wis. Stat. § 50.10 (establish right of action for violations "impairing the person's health, safety, personal care, rights or welfare"). Wisconsin's cause of action differs from Illinois' in that actions under the law are for mandamus against the Department or for injunctive relief against either the nursing facility or the Department, Wis. Stat. § 50.10(2), with the purpose being to "correct conditions in the nursing home or acts or omissions by the nursing home or by the [D]epartment." Wis. Stat. § 50.10(1). This distinction underscores that within our federal system, states may reasonably disagree over whether violations should be remedied through money damages or corrective action.

The Department has promulgated rules governing nursing facility care. *See* Wis. Admin. Code ch. DHS 132 ("Nursing Homes"). Those rules include one enumerating residents' rights, Wis. Admin. Code § DHS 132.31, which supplements the resident rights provided by statute, Wis. Stat. § 50.09(1). Violations of these enumerated rights are reported to the Department's Division of Quality Assurance pursuant to a review system mandated by law. Wis. Stat. § 50.09(6). In addition to its oversight of facility licensure and standards for residential life, the Department may issue sanctions ranging from correction action to forfeitures (up to $1,000 per violation per day) to license suspension or revocation. Wis. Stat. § 50.03(5g). All sanctions are subject to judicial review. Wis. Stat. § 50.03(11).

B. Administrative regulation and remedies under federal law

As Talevski acknowledges, nursing homes in Illinois, Indiana, and Wisconsin are also regulated through these states' participation in the federal Medicaid program, 42 U.S.C. § 1396 *et seq.* (*cf.* Talevski Br. at 4). Thus, in addition to their own unique enforcement regimes, states are required to monitor and enforce their nursing facilities' compliance with the Medicaid Act and regulations issued by the Centers for Medicare & Medicaid Services (CMS).

This second layer of administrative regulation is enforced through facility surveys to identify and remedy substantial non-compliance. Surveys are completed primarily by the same state health departments identified above, and results are reported in Quality, Certification and Oversight Reports ("QCORs") issued by CMS. According to a recent QCOR, the states within the Seventh Circuit have been very active in completing CMS surveys over the past few years:

—TABLE 2—
Centers for Medicare & Medicaid Services
Survey Activity within Seventh Circuit, 2018–2020[11]

Year	IL Surveys	IN Surveys	WI Surveys
2018	745 standard 3,412 complaint	540 standard 1,850 complaint	319 standard 842 complaint
2019	724 standard 4,162 complaint	533 standard 1,924 complaint	360 standard 860 complaint
2020 (to date)	140 standard 1,533 complaint	115 standard 864 complaint	83 standard 350 complaint
Total	1,609 standard 9,107 complaint	1,188 standard 4,638 complaint	762 standard 2,052 complaint

[11] QCOR, *Survey Activity Report*, available online for targeted searches at https://qcor.cms.gov/nh_wizard.jsp?which=0&report=new_count.jsp (last visited Oct. 1, 2020). The calendar-year figures in this table are limited to nursing homes and count a standard health survey and a standard life safety code survey as one survey.

CMS also maintains authority to conduct its own surveys independent of state departments of health to ensure compliance among nursing homes, and CMS frequently conducts follow-on surveys to confirm the accuracy of state surveys as well. The federal government therefore maintains an active role in ensuring adherence to its regulatory regime.

Just as in the state regimes, CMS surveys translate into enforcement actions against non-compliant facilities. And the data shows that in their role as federal enforcers, Illinois, Indiana, and Wisconsin are making ample use of the tools offered to them by FNHRA.[12] Over the past three years, the federal government has issued $7.14 million in fines to Illinois nursing facilities, $7.11 million in fines to Indiana nursing facilities, and $4.18 million in fines to Wisconsin nursing facilities.[13] These civil monetary penalties amount to a grand total of $18.43 million within the Seventh Circuit since 2018 alone—and this amount is over and above any penalties assessed under the state enforcement regimes discussed above.

CMS frequently uses other remedies in addition to or in lieu of civil monetary penalties, including directed plans of correction and discretionary denial of payment for new admissions (DDPNAs), the latter of which trigger nonpayment for any admissions after the DDPNA date unless corrections are completed and confirmed

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[12] *Cf.* Talevski Br. at 9 (describing "additional intermediate sanctions" made possible by FNHRA).

[13] L. Groeger and C. Ornstein, "Nursing Home Inspect," *ProPublica* (July 2020), available online at https://projects.propublica.org/nursing-homes/ (last visited Oct. 1, 2020) (summarizing data from the U.S. Centers for Medicare & Medicaid Services). With 720 nursing facilities in Illinois, 533 in Indiana, and 353 nursing facilities in Wisconsin, these figures are roughly proportionate per capita.

before that date. And regardless of any other remedy or remedies selected, all facilities are subject to mandatory denial of payment for new admissions if the facility does not demonstrate compliance within 90 days of a survey.

On top of this, CMS surveys drive a federal 'name and shame' initiative called the Special Focus Facility (SFF) program, a list reserved for nursing facilities that have a history of serious quality issues or are included in a special program to stimulate improvements in their quality of care.[14] Currently this list includes four facilities in Illinois, three in Indiana, and one in Wisconsin.[15] An SFF designation results in required surveys every six months, and facilities that fail to demonstrate improvement and "graduate" are terminated from participating in Medicare and Medicaid programs. Listing on this index can also attract litigation, discussed next.

C. Judicial remedies under state law

As noted above, both Illinois and Wisconsin provide private causes of action to nursing facility residents as a matter of state law. Because Illinois provides for attorney fees in such cases, nursing facility litigation is most attractive to plaintiffs there, but all three states have seen significant verdicts against owners and operators of nursing facilities *without* any federal right of action under § 1983.

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[14] CMS, "CMS Publishes National List of Poor-Performing Nursing Homes, Key Tool for Families Seeking Quality Care" (Nov. 29, 2007), available online at https://www.cms.gov/newsroom/press-releases/cms-publishes-national-list-poor-performing-nursing-homes-key-tool-families-seeking-quality-care (last visited Oct. 1, 2020).

[15] CMS, Special Focus Facility Program, Tables A–C (Feb. 26, 2020), available online at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/SFFList.pdf (last visited Oct. 1, 2020).

These verdicts make clear that even when state and federal oversight fail to prevent an unfortunate outcome, residents are not left without recourse in court.

In Illinois, one Cook County jury ordered a nursing facility to pay more than $4.1 million to the family of an 89-year-old woman whose death was attributed to an overlooked dose of medication.[16] Another jury in Cook County awarded $2.7 million to the estate of a man who died from complications relating to a fall.[17]

In Wisconsin, between 1986 and 2013, at least 297 personal injury, wrongful death, and medical malpractice lawsuits were filed against nursing and long-term care facilities.[18] One Wisconsin court awarded a plaintiff $1.44 million after finding that the defendant nursing facility failed to adequately care for him after he had entered a persistent vegetative state.[19] In another nursing facility malpractice case out of Brown County, plaintiff's counsel reported a $2.4 million settlement.[20]

But perhaps the most noteworthy examples come from Indiana. There, despite no private right of action under state law, strict caps on punitive damages (Ind. Code § 34-51-3-3) and medical malpractice recovery (Ind. Code § 34-18-14-3),

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[16] *Grauer v. Clare Oaks*, 2019 IL App (1st) 180835 (unpublished) (affirming jury verdict but reversing $1.3 million attorney fee award for redetermination).

[17] *Green v. Southpoint Nursing and Rehabilitation Center, et al.*, Cook County Case No. 14-L-11826 (judgment on verdict entered Nov. 8, 2017).

[18] Wisconsin Watch, "Nursing homes draw lawsuits" (Feb. 18, 2013), available online at https://www.wisconsinwatch.org/2013/02/nursing-homes-draw-lawsuits/ (last visited Oct. 1, 2020).

[19] *Estate of Thigpen v. Woodstock Health Care*, Kenosha County Case No. 17-CV-1048, 2020 WL 1327597 (judgment on verdict entered Jan. 17, 2020).

[20] Domnitz & Domnitz, S.C., "Verdicts and Settlements," available online at https://domnitzlaw.com/wisconsin-personal-injury-attorneys-firm/verdicts-and-settlements/ (last visited Oct. 1, 2020).

and an outright ban on punitive damages in wrongful death cases,[21] nursing facility residents have still recovered sizeable verdicts on common law tort claims, including a $1.5 million verdict in 2002,[22] a $5.3 million verdict in 2008,[23] and one $1.5 million verdict for a plaintiff whose bath was too hot.[24]

This evidence is anecdotal, and does not reflect the vast majority of suits against nursing facilities that are settled out of court, but it still illustrates a point: plaintiffs injured in nursing facilities do not *need* a private federal cause of action to vindicate their rights. Whether states offer their own private cause of action for damages (like Illinois), a more limited private cause of action for enforcement (like Wisconsin), or *no* private right of action (like Indiana), plaintiffs in all three states win significant damages when recovery is supported by the facts and existing law.

D. Judicial remedies under federal law

Just as with state administrative remedies, state law causes of action are coupled with resort to federal courts in cases of serious violations. Even without any private federal cause of action, federal cases may arise in one of two ways.

First, of course, any of the state law claims described above may be brought in federal court if the requirements for diversity jurisdiction are satisfied. Nursing

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[21] *Durham ex rel. Estate of Wade v. U-Haul International*, 745 N.E.2d 755, 757 (Ind. 2001).

[22] *Eggerding v. Chase Nursing Center*, Cass County Case No. 09C01-0003-CT-0006, JVR No. 404467, 2002 WL 32091634 (judgment on verdict entered Mar. 19, 2002).

[23] *Hanson v. Munster Medical Research Foundation, Inc.*, Lake County Case No. 45D02-0603-CT-000029, 2007 WL 5367302 (verdict entered Oct. 5, 2007; judgment entered Nov. 2, 2007 capped verdict at $2.5 million per Indiana Medical Malpractice Act).

[24] *Estate of McGhee v. Residential CRF Inc.*, Madison County Case No. 48DO3-0203-PL-233, JVR No. 488638, 2008 WL 3896198 (judgment on verdict entered Jan. 28, 2008).

facilities are often owned or operated by entities in other states, and the size of the verdicts above indicates that the amount in controversy requirement would have been satisfied in each of those cases. *Cf.* 28 U.S.C. § 1332(a).

Second, to the extent nursing facilities receive Medicaid payments, Medicaid Fraud Control Units (MFCUs) can proceed directly against such facilities in court—including for resident abuse. *See* 42 U.S.C. § 1396b(q)(1); 42 C.F.R. § 1007.7 ("Prosecutorial authority requirements of Unit"). Nationally, in 2019, MFCU cases resulted in 416 convictions for patient abuse or neglect, recovering $4,749,366 in criminal penalties. Twenty-eight of these convictions were specific to nursing facilities and accounted for $144,959 in penalties. In the same period, fifteen settlements with and judgments against nursing facilities yielded an additional $669,500 in civil recoveries—an average of nearly $45,000 per case.[25]

These figures confirm that federal enforcement via state MCFUs is robust, including specifically in cases of resident care, and includes resort to federal court for civil or criminal action when the MCFU deems it warranted. Tellingly, Talevski does not even mention MCFUs in his brief, despite that they constitute the primary mechanism created by Congress to enforce the promises of FNHRA's bill of rights in court and—by the numbers—are highly effective in doing so.

[25] U.S. Dept. of Health & Human Services, Office of Inspector General, *Medicaid Fraud Control Units Fiscal Year 2019 Annual Report* (Mar. 2020) at 20 (Appx. C), available online at https://oig.hhs.gov/oei/reports/oei-09-20-00110.pdf (last visited Oct. 1, 2020).

II. Turning complaints about nursing facility care into federal lawsuits will deplete the resources needed for proper care.

The discussion thus far confirms that a new, judicially-created right of action under § 1983 would be at best superfluous in light of existing state enforcement, federal enforcement, and judicial remedies available in state and federal court. The remainder of the argument explores what such a remedy might be at worst.

A. Federalizing every nursing facility complaint would strain the competence of federal courts.

In *Blessing v. Freestone*, 520 U.S. 329 (1997), the Supreme Court warned courts not to recognize "vague and amorphous" rights lest they "strain judicial competence" in attempting to enforce them. 520 U.S. at 340–41. Converting FNHRA's "bill of rights" into so many federal causes of action certainly risks doing that. While Talevski focuses only on purportedly clear prohibitions on chemical restraints and involuntary transfer or discharge (*cf.* Talevski Br. at 6–8), he offers no judicially administrable means of distinguishing between these and other provisions within FNHRA's "bill of rights," such as the rights to "voice grievances" and "prompt efforts by the facility to resolve grievances the resident may have," 42 U.S.C. § 1396r(c)(1)(A)(vi), or to "receive services with reasonable accommodation of individual needs and preferences," 42 U.S.C. § 1396r(c)(1)(A)(v)(I). Such rights, if converted to federal causes of action, would strain judicial competence not merely because they are vague and amorphous (that is, what do they *mean*?), but also because they would require some combination of administrative and medical expertise to adjudicate.

For starters, within the confines of a nursing facility, what qualifies as a "grievance," and which "individual needs and preferences" are worthy of federal judicial protection? One might suppose just about any detail of resident life—whether the room is too hot or too cold, whether the facility is too loud or too quiet—could satisfy either description. When do such matters of personal preference rise to the level of a mental or physical health concern, and who is most qualified to decide that—especially when the patient, her doctor, facility staff, and perhaps multiple family members all disagree?

State health departments in general, and their long-term care or quality assurance divisions in particular, exist precisely to resolve such matters. That is their stock in trade. If they get it wrong—and occasionally they may—judicial review is available in the state courts, which are also open to hear claims that rise to the level of statutory violations or common law torts. Engrafting the federal courts onto this system as a redundant level of nursing home management would turn every intramural disagreement into a federal question. No matter its solicitude for residents' rights, Congress cannot have intended that.

B. Taxing nursing facilities with federal lawsuits will drain resources needed for the care of residents.

Of course, the federal courts would not be the only ones taxed if every nursing facility resident is also a potential federal plaintiff. Nursing facilities themselves, already subject to overlapping state and federal regulation, MCFU litigation, and resident claims under state law, are already under significant administrative and fiscal pressure—particularly when Medicare and Medicaid reimbursement makes

up the bulk of their revenues. Subjecting these facilities to a whole new collection of federal claims will only increase the costs of resident care and divert attention and resources currently devoted to ensuring quality care is maintained.

"Numerous scholars have determined that actions by overly vigorous plaintiffs' counsel have resulted in an actual decrease in nursing home quality, hardly the goal of protectors of the meek and the weak."[26] In one survey of lawyers involved in nursing home litigation, the authors concluded that in states with a high volume of litigation, substantial nursing facility resources are diverted to defending against lawsuits.[27] In another study, Duke University researchers observed that litigation is associated with a decline in inspection-oriented measured quality in nursing homes that are subject to actual legal claims.[28] And Brown University researchers have found that an adversarial regulatory environment precludes advances in nursing home quality.[29]

A significant aspect of this dynamic is not even damages or the cost of litigation, but insurance costs. Already in 2005, Dr. Heidi White described "[r]apidly increasing liability insurance rates for nursing homes" as a "substantial financial

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[26] M. Wortham, "The Role of Litigation in the Quest for Better Care: A Critique of 'Litigating the Nursing Home Case,'" 12 No. 1 ANDREWS NURSING HOME LITIG. REP. 1 (July 2009) at 3.

[27] D. Stevenson and D. Studdert, "The Rise of Nursing Home Litigation: Findings from a National Survey of Attorneys, 22 HEALTH AFFAIRS 219–229 (2003).

[28] J. Troyer and H. Thompson, Jr., "The Impact of Litigation on Nursing Home Quality," 29 J. HEALTH POLITICS, POLICY & LAW 11–42 (2004).

[29] A. Gruneir and V. Mor, "Nursing Home Safety: Current Issues and Barriers to Improvement," 29 ANNUAL REVIEW OF PUB. HEALTH (2008).

issue that threatens the stability of the industry."[30] If that was true of insurance rates fifteen years ago, consider the destabilizing effect of inventing an entirely new class of federal claims not yet "priced in" by actuaries and for which insurance coverage does not currently exist.

In Indiana alone, one actuary known to InHCA has observed that this new, uncovered liability would expose members to unlimited losses, blowing through current maximum indemnity amounts and increasing premiums by 65.9% as a result. Clearly an increase of this magnitude would negatively impact health care costs, increase operating expenses for nursing facilities, and reduce the amount of money available to provide health care. Whether facilities pass these costs on to residents (in the case of private payers), respond by cutting services (in the case of Medicaid or Medicare reimbursement), or make the difficult decision to close their doors (jeopardizing access to care, especially in rural communities), the result is poorer outcomes for the very patients Talevski's counsel purport to protect.

CONCLUSION

This case presents the Court with a bid for a new federal cause of action based on the faulty premise that exposing nursing facilities to even greater liability will ultimately promote better outcomes for residents. If Congress had shared that view, it could have expressly adopted a private right of action and corresponding remedies in enacting FNHRA. Instead, it struck a more nuanced balance, describing

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[30] H. White, "Promoting Quality Care in the Nursing Home," 13 ANNALS OF LONG TERM CARE (2005).

the "rights" of residents but relying on cooperative federalism and new and existing administrative remedies to ensure those rights were observed. Far from helping residents like Talevski, federalizing nursing facility care under § 1983 would at best serve no purpose and at worst materially increase the cost of the care that nursing facilities are already providing. The Health Care Associations urge the Court to affirm that FNHRA provides no cause of action under § 1983.

Respectfully submitted,

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This amicus brief complies with the type-volume limit of Fed. R. App. P. 29(a)(5) because, excluding the parts of the document exempted by Fed. R. App. P. 32(f), this brief contains 5,393 words.

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CERTIFICATE OF SERVICE

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I hereby certify that on October 6, 2020, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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