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

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

BRIEF FOR THE AMERICAN HEALTH CARE ASSOCIATION, INDIANA HEALTH CARE ASSOCIATION, ILLINOIS HEALTH CARE ASSOCIATION, AND WISCONSIN HEALTH CARE ASSOCIATION, INC. AS AMICI CURIAE SUPPORTING PETITIONERS

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INTEREST OF AMICI CURIAE

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

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

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[*] No counsel for a party authored this brief in whole or in part, and no person other than the amici curiae, their members, or their counsel made a monetary contribution intended to fund the preparation or submission of this brief. Counsel of record for petitioners and respondent have filed letters granting blanket consent to the filing of amicus briefs in support of either or neither party.

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

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's senior citizens and others facing physical and mental challenges in Illinois.

The Wisconsin Health Care Association, Inc. (WHCA) is a non-profit organization founded in 1951 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 its WiCAL division represent 190 SNFs and 228 assisted living centers in Wisconsin.

AHCA, InHCA, IHCA, WHCA, and their respective members have a substantial interest in this case.

In reversing a district court's judgment to the contrary, the United States Court of Appeals for the Seventh Circuit held that certain Medicaid provisions enacted by OBRA create federal "rights" that can be privately enforced against NFs that are owned or operated by state or local governments, using damages suits under 42 U.S.C. § 1983. Pet. App. 3a; *see also* 42 U.S.C. § 1983 (providing that "[e]very person who, under color of any statute, ordinance, regulation, custom, or usage, of any State . . . subjects . . . any citizen of the United States or other person within the jurisdiction thereof to the deprivation of *any rights . . . secured by the* Constitution and *laws*, shall be liable to the party injured in an action at law") (emphasis added). This Court, in turn, granted certiorari on two questions: (1) whether the Court should reexamine its holding that Spending Clause legislation can give rise to privately enforceable "rights" under § 1983; and (2) whether, assuming Spending Clause legislation can give rise to such "rights," the provisions of OBRA at issue here do so. *See* Pet. i–ii.

SUMMARY OF ARGUMENT

The Court need not reexamine its Spending Clause holding in order to resolve this case. Instead, consistent with the approach recently taken in *Vega v. Tekoh*, 142 S. Ct. 2095 (2022), the Court should assume that Spending Clause legislation can create "rights" enforceable under § 1983 but reverse the Seventh Circuit's judgment because that judgment rests on a misunderstanding of congressional intent.

Contrary to this Court's opinion in *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), the judgment below fails to take into account the complete breadth of the statutory changes enacted by

OBRA and the context in which those changes operate. OBRA made nearly identical changes to the Medicare and Medicaid Acts, applying the same standards regardless of whether the facility participating in those programs is a private actor (as the vast majority are) or a public actor. What OBRA did not do, however, was include an express private right of action in either the Medicare or Medicaid Acts. And courts have overwhelmingly (and correctly) held that OBRA's amendments to the Medicare and Medicaid Acts did not create an implied private right of action.

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

Had Congress truly intended such disparate treatment of similarly situated participants in two government programs—whereby public participants in both programs are subject to *greater* litigation risk than their private counterparts for allegedly violating the *same* participation requirements—surely Congress would have said so using unambiguous statutory language, particularly given how anomalous such a scheme would be in our federalist system of government. Congress included no such language in OBRA. In the absence of such clear and unambiguous statutory language, the Court should not ascribe to Congress an illogical intent to single out public actors

for disfavored treatment by subjecting them and only them to damages suits seeking millions of dollars for alleged violations of Medicare and Medicaid participation requirements.

ARGUMENT

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

The Court recently faced the threshold question whether judicially created rules—as opposed to the Constitution or statutes—could create "rights" enforceable under § 1983. *See Vega*, 142 S. Ct. at 2106 n.6 (noting threshold issue in context of deciding whether rules established in *Miranda v. Arizona*, 384 U.S. 436 (1966), create "rights" enforceable under § 1983). However, instead of deciding that threshold question, the Court assumed for purposes of its decision that judicially created rules were capable of creating such "rights" yet decided that violations of the particular rules at issue did not give rise to § 1983 liability. *See id.*

The Court should follow a similar course here by assuming for purposes of its decision that Spending Clause legislation can create "rights" enforceable under § 1983. Congress has long known that the Court has found Spending Clause legislation—particularly Spending Clause legislation directed specifically at States and/or local governments but not private actors—is capable of creating "rights" enforceable under § 1983. *See Maine v. Thiboutot*, 448 U.S. 1, 4 (1980) (finding § 1983 could be used to enforce welfare provision of Social Security Act imposing requirements on

participating States only and not on private actors); *Wright v. Roanoke Redevelopment & Housing Auth.*, 479 U.S. 418, 424 (1987) (finding § 1983 could be used to enforce Brooke Amendment to the United States Housing Act of 1937 imposing rent limits on public housing agencies only and not on private actors); *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 524 (1990) (finding since-repealed Boren Amendment to the Medicaid Act, which imposed requirements on participating States only and not on private actors, created a "right, enforceable in a private cause of action pursuant to § 1983, to have the State adopt [Medicaid payment] rates that it finds are reasonable and adequate rates to meet the costs of an efficient and economical health care provider").

In the decades since, Congress has not expressed disagreement with that holding even though Congress has enacted legislation disagreeing with *other* § 1983 decisions issued by the Court. *See* Improving America's Schools Act of 1994, Pub. L. No. 103-382, § 555(a), 108 Stat. 3518, 4057 (codified at 42 U.S.C. § 1320a-2) (expressing disagreement with aspects of *Suter v. Artist M.*, 503 U.S. 347 (1992)); Social Security Amendments of 1994, Pub. L. No. 103-432, § 211(a), 108 Stat. 4398, 4460 (codified at 42 U.S.C. § 1320a-10) (same); Federal Courts Improvement Act of 1996, Pub. L. No. 104-317, § 309(c), 110 Stat. 3847, 3853 (amending § 1983 in order to narrow circumstances in which relief may be sought against judicial officers); S. Rep. No. 104-366, at 36–37 (1996) (explaining foregoing statutory amendment expressed disagreement with *Pulliam v. Allen*, 466 U.S. 522 (1984)), *reprinted in* 1996 U.S.C.C.A.N. 4202, 4216. Therefore, the best approach here would be to forgo

reevaluating the Spending Clause holding because doing so raises complex statutory *stare decisis* questions. *Cf. Monell v. N.Y.C. Dep't of Soc. Servs.*, 436 U.S. 658, 714 (1978) (Rehnquist, J., dissenting) (criticizing majority's overturning of precedent interpreting § 1983's use of the word "person" where, as here, Congress had not enacted legislation expressing disagreement with the Court's past decisions on that question).

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

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

is what Congress intended." *Id.* (internal quotation marks and citation omitted).

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

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

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

(quoting 42 U.S.C. § 1396-1). "Like other Spending Clause legislation, Medicaid offers the States a bargain: Congress provides federal funds in exchange for the States' agreement to spend them in accordance with congressionally imposed conditions." *Id.*

Importantly, since the inception of the Medicare and Medicaid programs, participation in both programs as a provider of services has been open to both private actors (who make up the vast majority of providers) and units of state and local government. For example, according to statistics published by the Centers for Medicare & Medicaid Services (CMS), there are currently 15,472 Medicare-participating SNFs in the United States, only 991 of which—or just 6.41 percent—are owned by a governmental entity. *See* Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities, 87 Fed. Reg. 22,720, 22,798 (proposed Apr. 15, 2022). This is not a recent phenomenon. At the time of OBRA's enactment, private actors made up the vast majority of providers in the treatment setting at issue here. *See, e.g.*, Inst. of Med., *Improving the Quality of Care in Nursing Homes* 10 (Mar. 1986) (reporting that only 8 percent of such facilities were owned by a governmental entity), *available at* http://nap.edu/646 (last visited July 15, 2022); H.R. Rep. No. 100-391, pt. 1, at 452 (1987) (discussing Institute of Medicine report and explaining recommendations therein informed drafting of OBRA), *reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-272; Survey and Certification of Health Care Facilities, 52 Fed. Reg. 44,300, 44,304 (proposed Nov. 18, 1987) (explaining, in the month prior to OBRA's passage, that the vast majority of such facilities were operated by private actors).

Nor is this a phenomenon unique to SNFs/NFs. Private ownership predominates in other treatment settings as well. *See, e.g.*, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System, 87 Fed. Reg. 28,108, 28,731–32 (proposed May 10, 2022) (reporting that of the 3,141 Medicare-participating acute care hospitals in the United States, only 439—or just 13.98 percent—are owned by a governmental entity); *id.* at 28,736 (reporting that of the 337 Medicare-participating long-term care hospitals in the United States, only 11—or just 3.26 percent—are owned by a governmental entity); Medicare Program; FY 2023 Hospice Wage Index and Payment Rate Update, 87 Fed. Reg. 19,442, 19,461 (proposed Apr. 4, 2022) (reporting that of the 5,186 Medicare-participating hospices in the United States, only 121—or just 2.33 percent—are owned by a governmental entity); Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2023, 87 Fed. Reg. 20,218, 20,261 (proposed Apr. 6, 2022) (reporting that of the 1,115 Medicare-participating inpatient rehabilitation facilities in the United States, only 107—or just 9.6 percent—are owned by a governmental entity); Medicare Program; FY 2023 Inpatient Psychiatric Facilities Prospective Payment System, 87 Fed. Reg. 19,415, 19,439 (proposed Apr. 4, 2022) (reporting that of the 1,418 Medicare-participating inpatient psychiatric facilities in the United States, only 289—or just 20.38 percent—are owned by a governmental entity).

Moreover, in the specific treatment setting at issue here, most facilities (including the facility in this case) participate in both Medicare and Medicaid. Such dual-

participating facilities fall within the definition of a SNF *and* a NF, and serve both Medicare and Medicaid beneficiaries. *See, e.g.*, Ctrs. for Medicare & Medicaid Servs., *Nursing Facilities*, https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/nursing-facilities/index.html (last visited July 15, 2022) (explaining that "[i]n many cases it is not necessary to transfer to another nursing home when payment source changes to Medicaid NF" because "[m]any nursing homes are also certified as a Medicare [SNF]").

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

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

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

Start with something on which everyone agrees: OBRA did not add an express private right of action to either the Medicare or Medicaid Acts. *See, e.g.*, *Grammer v. John J. Kane Reg'l Ctrs.-Glen Hazel*, 570 F.3d 520, 525 n.2 (3d Cir. 2009) ("Residents of nursing homes cannot directly sue to enforce compliance with federal standards. The statutes at issue in this case do not expressly authorize private causes of action to enforce their provisions and the parties do not dispute this."), *cert. denied*, 559 U.S. 939 (2010) (No. 09-696).

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

implied private right of action exists under the Medicaid Act [or] OBRA").

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

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

> Unlike legislation enacted under § 5 [of the Fourteenth Amendment], . . . legislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions. The legitimacy of Congress' power to legislate under the spending power thus rests on

> whether the State voluntarily and knowingly accepts the terms of the 'contract.' . . . . There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it. Accordingly, if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously. . . . By insisting that Congress speak with a clear voice, we enable the States to exercise their choice knowingly, cognizant of the consequences of their participation.

451 U.S. at 17.

OBRA contains no such language.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be reversed.

Respectfully submitted.

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