No. 21-806

IN THE

Supreme Court of the United States

HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY, *et al.*,

Petitioner,

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 THE INDIANA TRIAL LAWYERS ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT

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INTERESTS OF THE *AMICUS CURIAE*

Petitioners accepted federal funding knowing the inherent liability risk for violations of federal laws and regulations, including the Federal Nursing Home Reform Act of 1987 ("FNHRA"). Now, faced with that reality, they ask this Court to strip nursing home residents of their ability to enforce the rights explicitly bestowed on them in that agreement. Nearly all of Indiana's nursing homes are owned by county hospitals. Determining those residents do not have a private right of action under 42 U.S.C. § 1983 to enforce FNHRA would leave residents in those homes without a remedy when county hospitals fail to uphold their end of the bargain. Federal rights violations are just one of many harms that occur in nursing homes. Indiana's laws combine procedural obstacles, remedy limitations, and immunities that preclude meaningful recovery for many of those harms. Though many states have enacted private rights of action for violations of state statutes mirroring FNHRA, Indiana has not. In Indiana, Section 1983 claims fill a crucial void, to redress harms intentionally inflicted upon our most vulnerable population. The Indiana Trial Lawyers Association ("ITLA") is dedicated to the constitutional rights of open access to the courts and equal protection under the law for all persons in Indiana. ITLA has an important interest in protecting the rights of Indiana's vulnerable nursing home residents and their ability to access the courts.[1]

1. Pursuant to Sup. Ct. R. 37.6, no counsel for a party authored this brief in whole or in part, and no person other than the *amicus curiae*, their members, or their counsel made a monetary contribution intended to fund the preparation or submission of this brief. Pursuant to Sup. Ct. R. 37.3(a), 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.

SUMMARY OF THE ARGUMENT

I. Petitioners knowingly accepted federal funding in exchange for their agreement to uphold nursing home residents' rights under FNHRA, among other things. This agreement was a calculated risk that paid off greatly for the State and Petitioners, but compromised care provided to residents of Petitioners' nursing homes. 94% percent of Indiana's nursing homes are owned by county hospitals.[2] In 2021, those county hospitals received a whopping $1 billion windfall of federal tax dollars intended to fund nursing home care for Medicaid beneficiaries. Despite receiving more supplemental federal funding than any state in the nation for well over a decade, Indiana's nursing homes are some of the most poorly staffed and consistently rank near the bottom of national reviews of quality indicators. Underfunding nursing homes deprives residents of their rights under FNHRA and causes them harm. Petitioners knew of the liability risk for intentional violations of FNHRA and accounted for it in their management agreement governing the operation of the nursing homes. They've assumed that risk for the past nineteen years, and in exchange, they've accepted billions of federal dollars intended to fund nursing home care. Their failure to use that money as intended inevitably resulted in violations of FNHRA. Now, they've asked this Court to reverse the Seventh Circuit's

2. Nationally, less than 7% of nursing homes are owned by the government. There are 991 government-owned nursing homes in the nation, and 497 of them are in Indiana.

upholding of nursing home residents' ability to hold them accountable for harms resulting from those choices, so they can continue to accept federal funding without liability risk for violating residents' rights.

II. The ability to enforce residents' rights under FNHRA in a Section 1983 private right of action is necessary to address harms that occur in Indiana nursing homes. Harms in nursing homes do not all stem from medical malpractice. Residents require a variety of legal mechanisms to seek redress based on the specific harm at issue. Until the Seventh Circuit's decision, below, Indiana nursing home claims were awkwardly forced through the statutory process established for medical malpractice. This has proven to be insufficient and unworkable. There, claims are subject to procedural obstacles, contributory negligence, damage caps, forced arbitration, or a combination of the foregoing, all to the nursing home resident's detriment. Nursing home residents should not be exempt from the general rule that plaintiffs may choose their cause of action and pursue all claims concurrently. Petitioners' desire to foreclose residents' federal rights is not justification to do so.

III. The statutory context does not rebut the presumption that the individual rights at issue are enforceable under Section 1983. The administrative remedies of FNHRA do not redress resident harm and are not incompatible with individual enforcement under Section 1983.

> Those measures are directed by the facility, the State and/or federal regulatory agencies, and are aimed at stopping ongoing rights violations. Occasionally an administrative complaint may remedy some specific, minimal harm. But often, aggrieved nursing home residents—like Petitioners—require cash to serve their own interests.

ARGUMENT

I. PETITIONERS KNEW OF THE LIABILITY EXPOSURE FOR VIOLATIONS OF FEDERAL LAW AND REGULATIONS, INCLUDING FNHRA, WHEN THEY ACCEPTED FEDERAL FUNDING.

A. Petitioners accepted the liability risk for violations of FNHRA because it was incredibly lucrative.

Gorgi Talevski ("Talevski"), like many other Hoosiers, resided in a nursing home owned by a county hospital and operated by a private for-profit management company. Pet. App. at 76a-77a. Petitioner, the Health & Hospital Corporation of Marion County ("HHC") is an Indiana municipal corporation and political subdivision of the State of Indiana formed pursuant to I.C. § 16-22-8-6. Pet. App. 77a. At the time of filing, HHC, is the licensee of seventy-eight nursing homes across the State of Indiana. *Ibid.*

Petitioner, American Senior Communities, L.L.C. ("ASC"), is a private, for-profit limited liability company

that operates all HHC's nursing homes.[3] *Ibid.* Together, the State of Indiana, HHC, and ASC manipulate the Medicaid Upper Payment Limit ("UPL") reimbursement system to obtain significant windfalls at the expense of nursing home residents.[4] Specifically, HHC obtains maximum federal funding—through illusory state ownership of health facilities—and then siphons those funds out of the facility where the beneficiaries entitled to those benefits reside.[5, 6]

ASC and other private management companies are paid a "base management fee" out of the facility's operating budget and an "incentive management fee" equal to the difference between net resident revenues and the facilities operating expenses (including its base management fee). *Burkhart v. U.S.*, 1:18-cv-04013 (S.D. Ind. 2018), ECF Dkt. 2-3 at 22-23. ASC is thereby incentivized to minimize resources because its own compensation is directly tied to lowering facility operating expenses. The State, HHC,

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3. ASC does not manage any facilities other than those owned by HHC. All facilities are located in Indiana.

4. *See,* Tim Evans, Emily Hopkins, and Tony Cook, *Careless*, Indianapolis Star, Mar. 11, 2020, https://www.indystar.com/in-depth/news/investigations/2020/03/11/indiana-nursing-home-patients-suffer-medicaid-money-diverted-hospitals/2517834001/.

5. *Ibid.*

6. Twenty-three other Indiana county hospitals have joined this façade. 497 of Indiana's 527 nursing homes are owned by county hospitals and operated by private management companies. Indiana State Department of Health, *Health Care Providers Consumer Reports*, https://isdh.maps.arcgis.com/apps/webappviewer/index.html?id=ce9b358f567b49198bcf202133c49da7.

and ASC profit, while Indiana nursing home residents are deprived of their federally funded healthcare benefits.

This practice has been a subject of controversy throughout the years, with the Centers for Medicare and Medicaid Services' (CMS) now-former Administrator, Seema Verma, expressing her concern about the dangerous prospect of private nursing homes, in conjunction with local governmental health agencies, inappropriately allocating supplemental payments away from nursing homes, resulting in nursing home residents receiving little to no benefit of such supplemental payments:

> "In another example, a private nursing home (*sic*) makes a deal to 'sell' their license or enter into a lease arrangement with local government. Under this arrangement, however, the private nursing home maintains operational control of the facility, but by nominally changing their ownership status, the nursing home can suddenly be classified as 'governmental.' The local government agrees to fund the state share of additional Medicaid payments on their behalf, and the additional payments are then split between the private operators of the nursing home and the local government. Everyone wins – except perhaps the patient and certainly the federal taxpayer."

Seema Verma, *Medicaid Fiscal Integrity: Protecting Taxpayers and Patients*, Centers for Medicare & Medicaid Services (Feb. 12, 2020), https://www.cms.gov/blog/medicaid-fiscal-integrity-protecting-taxpayers-and-patients, [https://web.archive.org/web/20200603140250/

https://www.cms.gov/blog/medicaid-fiscal-integrity-protecting-taxpayers-and-patients] (last accessed Sept. 19, 2022).

Because of this opportunity to realize a windfall, HHC made a strategic decision to accept federal funding in exchange for its promise to comply with Federal Nursing Home Reform Act of 1987 FNHRA. It paid off. HHC received supplemental funding to the tune of $244,812,507.00 in the 2021 fiscal year.[7]

B. Petitioners negotiated their liability risk related to violations of federal laws and regulations before they accepted federal funds.

Petitioners claim, "state and local governments have been burdened by litigation costs and hefty damages—arising from unpredictable and shifting multi-factor balancing tests—that they never anticipated when they agreed to accept federal funding." Br. 2. But Petitioners and the State went into the nursing home business with eyes wide open. As a county hospital, HHC was in a unique position to qualify for maximum Medicaid reimbursement resulting from the Indiana legislature's passing new legislation to that end. *See* Daniel L. Hatcher, *The Poverty Industry: The Exploitation of America's Most Vulnerable Citizens,* p. 193-94, New York University Press (2016) (internal citations omitted). It purchased the licenses of twelve for-profit nursing homes, managed by ASC, and

7. Myers and Stauffer, Long-Term Care, IN NSGO UPL Report – SFY 2021 Final Payment data; *available at*: https://www.mslc.com/Indiana/Resources/Documents.aspx (last accessed on Sept. 20, 2022).

immediately contracted all operational responsibilities right back to ASC. *Id.* at 194-95 (internal citations omitted).

As this Court has recognized, "[w]hen Congress attaches conditions to the award of federal funds under its spending power, U.S. Const., Art. I, § 8, cl. 1, . . . we examine closely the propriety of private actions holding the recipient liable in monetary damages for noncompliance with the condition." *Gebser v. Lago Vista Indep. Sch. Dist.*, 524 U.S. 274, 287 (1998) (internal citations omitted). The Court's "central concern in that regard is with ensuring 'that the receiving entity of federal funds [has] notice that it will be liable for a monetary award.'" *Id.* at 287 (internal citation omitted). The facility management agreement between HHC ("Owner") and ASC ("Manager"), effective January 1, 2003, and updated from time to time, confirms HHC's notice of its liability risk by inclusion of the following:

> "Legal Requirements" means **any** (i) **law, code, rule, ordinance or regulation applicable to [HHC],** [ASC] **and/or any Facility or the operation thereof**; (ii) any order of any governmental authority having jurisdiction over [HHC], [ASC] and/or any Facility or the operation thereof; and (iii) **any law, code, rule, regulation**, bulletin, **decision, ruling or opinion applicable to reimbursement by Medicare, Medicaid or any other governmental healthcare program for services rendered at the Facilities.**

> "Litigation" means: (i) **any cause of action commenced in a federal**, state or local court **in the United States relating to any Facility and/or the ownership or operation of thereof**; (ii) any claim brought before an administrative agency or body (including, without limitation, employment discrimination claims) relating to any Facility and/or the ownership or operation thereof.

Burkhart, supra. at 8 (emphasis added).[8]

> ARTICLE 6 — INDEMNIFICATION AND HOLD HARMLESS
>
> The provisions of this Article 6 shall survive the termination or the expiration of this Agreement.
>
> 6.1 Indemnification
>
> 6.1.1 **[HHC] agrees to indemnify and hold harmless [ASC]**, its shareholders, trustees, directors, officers, employees and agents (each a "[ASC] Indemnified Party" and collectively the "[ASC] Indemnified Parties")

8. The coexistence of federal and state laws and regulations, administrative and agency authority, and laws and regulations promulgated by government healthcare program (i.e., HHS and CMS) in these definitions is fatal to Petitioners', and their supporting *amici*'s, contention that the "elaborate enforcement scheme" of 42 C.F.R. § 483.10(j)(4) and/or 42 U.S.C. § 1396r(c)(1)(A)(vi) displaces, and is incompatible with, a federal law private right of action.

from and against any and all losses, claims, damages, liabilities, costs and expenses (including reasonable attorneys' fees and expenses related to the defense of any claims) (collectively referred to herein as "Losses"), which may be asserted against any of the [ASC] Indemnified Parties arising in connection with: (i) any breach by [HHC] of its respective representations, warranties, covenants or agreements set forth in this Agreement; (ii) any act or omission by any employee of [HHC]; and (iii) **any violation of any requirement applicable to [HHC] under any federal, state or local law or regulation**; provided that such Losses have not been caused by the negligence or willful or wanton misconduct of the [ASC] or [ASC] Indemnified Party seeking indemnification pursuant to this Agreement.

6.1.2 **[ASC] agrees to indemnify and hold harmless [HHC]**, and its directors, officers, trustees, employees or agents (each a "[HHC] Indemnified Party" and collectively the "[HHC] Indemnified Parties") **from and against all Losses that may be asserted against any of the [HHC] Indemnified Parties as a result of**: (i) the acts or omissions of any personnel employed, leased or supervised by [ASC] who perform[ ] (sic) services at any Facility , but only to the extent that [ASC] is negligent in its supervision and/or hiring of such personnel employed, leased or supervised by [ASC]; (ii) any act or omission by [ASC] or any employee

> or agent of [ASC]; (iii) the negligence of [ASC], but only to the extent Losses incurred as a result of such negligence are not reimbursed by insurance; (iv) any breach by [ASC] of its respective representations, warranties, covenants or agreements set forth in this Agreement, including without limitation, the failure by [ASC] to perform its duties under this Agreement; (iv) **any violation of any federal, state or local law or regulation, to the extent such violation occurred as a result of acts or omissions that [ASC] or its employees or agents took or failed to take;** or (v) any allegation of infringement of any patent, trademark, copyright, trade secret or other intellectual property rights based on or arising from the management or operation of the Facilities; provided that such Losses have not been caused by the negligence or willful or wanton misconduct of [HHC] or [HHC] Indemnified Party seeking indemnification pursuant to this Agreement; provided that such Losses have not been caused by the negligence or willful or wanton misconduct of the [ASC] or [ASC] Indemnified Party seeking indemnification pursuant to this Agreement.

Id. at 25-26 (emphasis added).

Thus, HHC's risk of liability from "claims, damages, liabilities, costs and expenses (including reasonable attorneys' fees and expenses related to the defense of any claims" "arising in connection with" "any violation of any requirement applicable to [HHC] under any federal,

state or local regulation" whether sounding in breach of an express or implied contract, negligence, or intentional misconduct was contemplated and accounted for at the outset of Petitioners' joint, for-profit nursing home business. *See, Id.* To answer the question this Court posed in *Cummings v. Premier Rehab Keller, P.L.L.C.*: there is no doubt whether "prospective funding recipient," [HHC], "at the time it 'engaged in the process of deciding whether [to] accept' federal dollars, would have been aware that it would face such liability." 142 S.Ct. 1562, 1570-71 (2022) (internal citation omitted).

Congress "intend[ed] to impose [the] condition[s]" outlined in FNHRA and its implementing regulations set by the Secretary "on the grant of federal [Medicaid] money." *See*, *Cummings* 142 S.Ct. at 1570. HHC "received those funds "*on notice* that, by accepting federal funding, it [ ] expose[d] itself to liability" for **any violation of any requirement applicable to HHC under any federal . . . law or regulation**. *Ibid.*; See, Burkhart, *supra.* (emphasis added). Accordingly, this Court can "be confident that [HHC] exercised its choice knowingly, cognizant of the consequences of its participation in the federal program." *Ibid.* (internal citation omitted). Talevski sued under Section 1983 based on HHC's violation of requirements established under FNHRA.

The fact that HHC is a government entity enables it to uniquely benefit from its nursing home ownership by drawing down a surplus of federal funds. It also enables the residents of HHC's seventy-eight nursing homes to hold it accountable for federal rights violations under Section 1983. There is no reason HHC should not assume the known risk incumbent on its receipt of billions of

federal tax dollars since it acquired its first nursing home license in 2003.

C. Petitioners' business practices result in violations of rights under FNHRA.

Despite the surplus of federal dollars flowing into Indiana's nursing homes, the American Association of Retired Persons (AARP) ranks the State as one of the seven worst in the country in overall quality of long-term care facilities.[9] This is because the counties choose not to spend those funds in the nursing home. *See* Evans, *supra.* at n.4.

So, where does the money go? Most of the supplemental cash funds the county hospital's pet projects elsewhere (sometimes across the state) to allow them to compete with private medical providers.[10, 11] The following image

9. *See,* AARP, *Indiana: 2020 Long-Term Services and Supports (LTSS) State Scorecard,* https://www.longtermscorecard.org/~/media/Microsite/State%20Fact%20Sheets/Indiana%20Fact%20Sheet.pdf(last visited September15, 2022).

10. *See,* Phil Galewitz, *Chasing Millions in Medicaid Dollars, Hospital Buy Up Nursing Homes,* Kaiser Health News, (Oct. 13, 2017), *available at* https://www.washi ngtonpost.com/business/economy/chasing-millions-in-medicaid-dollars-hospitals-buy-up-nursing-homes/2017/10/13/2be823ca-a943-11e7-92d1-58c702d2d975_story.html.

11. Seven of those county hospitals have refused to publicly account for the funds entirely and were sued under the Access to Public Records Act as a result. *Gannett Satellite Information Network, LLC d/b/a/ The Indianapolis Star, et al. v. Hancock Regional Health, et al.,* 49D01-2208-MI-026560 (Marion Co. Sup. Ct. 1, Ind., Aug. 4, 2022).

shows the proximity of HHC-ASC's facilities from Marion County (center, dark yellow), where the supplemental Medicaid funds obtained based on residents' care needs from all HHC-ASC homes are ultimately invested:

HHC-ASC facility map *available at*: https://hhcorp.org/about_longtermcare_OurFacilities.html, (last visited on Sept. 21, 2022).

It is clear many of the residents do not receive even a tangential benefit from HHC's use of federal funds obtained on their behalf.

To the extent *amici* in support of Petitioners assert that "county-owned facilities often offer the best patient outcomes" (NCSL, et al. Br. 10) and caution the "privatization" of Indiana's county-hospital owned facilities would harm patients (*Id.* at 9-12), those sentiments do not apply to nursing homes owned by HHC. Because Indiana's county hospitals contract away all operational responsibility to private management companies immediately upon purchase, these nursing homes are already more akin to those owned by private for-profit companies than they are to a mom-and-pop county owned *and operated* nursing home. *See,* Hatcher, *supra.* at 194-5. To this point, in August 2022, ASC settled a False Claims Act case with the Department of Justice (DOJ) for $5.5 million.[12]

The DOJ alleged ASC had engaged in conduct to defraud the Medicare program by double-charging for various therapy services. *Ibid.* As the CMS data, *infra.*, confirms, the HHC-ASC facilities could not rank much lower in terms of staffing, health inspections, quality measures or overall ratings. Given the substantial cash flowing into HHC and ASC's pockets by virtue of their business practices, funding care should not be a problem. Yet, it is.

The supplemental funding amount is calculated based on the needs of its nursing home residents, determined by health evaluations that assess their individual acuity

12. Dept. of Justice, U.S. Attorney's Office, *See, U.S. Attorney's Office Recovers Over $5.5 Million in Civil False Claims Settlement with American Senior Communities* (Aug. 10, 2022), https://www.justice.gov/usao-sdin/pr/us-attorney-s-office-recovers-over-55-million-civil-false claims-settlement-american.

levels. So, CMS provided HHC with the funding calculated to reimburse it at the Medicare rate for the treatment necessary to care for its Medicaid resident population, based on their individual needs. What amount and quality of care was provided? CMS rated the care provided in HHC-ASC's seventy-eight nursing homes as follows:

Overall Rating	Health Inspections	Staffing	Quality Measures
1 star: 8 **homes**	1 star: 5 homes	**1 star:** **29 homes**	1 star: 0 homes
2 star: **12 homes**	2 star: 22 homes	**2 star:** **35 homes**	2 star: 0 homes
3 star: **20 homes**	3 star: 14 homes	**3 star:** **11 homes**	3 star: 12 homes
4 star: 16 homes	4 star: 30 homes	4 star: 3 homes	4 star: 16 homes
5 star: 22 homes	5 star: 7 homes	5 star: 0 homes	5 star: 50 homes

See, CMS Care Compare Nursing Home Star ratings, available at: https://www.medicare.gov/care compare/?providerType=NursingHome&redirect=true (last visited Sept. 19, 2022).

Over 82% of HHC-ASC facilities are staffed **below** the national average. *Ibid.* Four homes have abuse warnings. *Ibid.* Over half have an overall rating at or below the national average. *Ibid.* Understaffing matters. It is one

of the primary causes of inadequate care and unsafe conditions in health facilities. Understaffing can lead to the following indignities and harms:

- no response or long response times to call lights;
- lack of assistance with grooming and bathing;
- inadequate attention to toileting needs, forcing residents to sit in undergarments and bedclothes soaked in urine or feces;
- rough and painful handling by staff;
- lack of assistance with eating;
- failure to provide fluids as needed, resulting in dehydration and frequent urinary tract infections;
- malnutrition;
- falls resulting in injuries;
- pressure sores;
- failure to administer medications or improper administration of medications;
- loss of personal items and medical devices;
- failure to provide pain control;
- over-sedation;

- and lack of proper hygiene and infection control measures.

As discussed, *infra*. at II(A)-(B), these harms, which result from the intentional understaffing of the facility, are not appropriately redressed by Indiana's medical malpractice laws.

II. WITHOUT SECTION 1983 CLAIMS, INDIANA NURSING HOME RESIDENTS LACK ADEQUATE RECOURSE.

A. Nursing home residents require a variety of remedies to address a variety of possible harms.

Medical malpractice claims cannot address every potential harm that occurs in a nursing home. Nursing homes are multi-faceted. It is the residents' home, their place of medical, nursing, and other health care, their barber shop, their bank, their local restaurant, their backyard, their bingo hall, and their place of worship. Each of those activities comes with inherent risk. For this reason, addressing harms that result from nursing home residency is a fact-specific inquiry. *See, Doe by Roe v. Madison Ctr. Hosp.*, 652 N.E.2d. 101, 104 (Ind. Ct. App. 1995) (When deciding whether a claim falls under the Indiana Medical Malpractice Act, courts are directed to look to the substance of a claim to determine the applicability). Several factors determine whether a claim(s) exists, what type of claim it is, how it may be pursued, and what relief is available.

Based on the breadth of services and activities inherent to nursing home operation, claims may arise from

negligence, civil rights violations, medical malpractice, nursing negligence, premises liability, breach of contract, financial harms, reputational harms, corporate misconduct, or even intentional torts. *Burkhart, supra.*, at 8; 25-26. Petitioners recognized this and crafted an indemnity agreement contemplating all the foregoing claims. This makes sense. Residents do not check their Constitutional, federal, or state law rights at the nursing home door. Conversely, they acquire additional "residents'" rights under FNHRA by virtue of admission.[13] The ability to enforce individual rights under Section 1983 co-exists with their ability to seek recourse for negligent medical treatment in all other settings—there is no basis to deprive nursing home residents of the same.

Petitioners' and their supporting *amici's* assertion that the Seventh Circuit's decision allowing Section 1983 claims based on violations of FNHRA "federalized medical malpractice" and "swe[pt] aside carefully chosen state policies in favor of a one-size-fits-all [regime]" (*See,* Pet. Br. at 9; NCSL Br. at 13) is axiomatic. The decision conferred a private right of action *in addition to* existing state law remedies. There was no previous private right of action for FNHRA resident's rights violations or the analogous Indiana Administrative Code regulations. Indiana medical malpractice claims will not be displaced. Claims arising under Section 1983 to enforce rights violations will proceed in federal court, relieving the State of the administrative and judicial burden associated with

13. The Attorney General's ability to seek remedies for nursing homes' patterns or practice of conduct that violate FNHRA under the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 12133 ("CRIPA") supports this notion.

those proceedings. Further, where Indiana's "carefully chosen state polic[y]", *Ibid.*, to allow county hospitals to obtain and divert supplemental federal funding out of nursing homes is the source of the claim, federal law and regulations governing receipt of that funding should control.

Respondent's allegations that Talevski was intentionally chemically restrained for the purpose of convenience, in violation of 42 U.S.C. § 1396(r)(c)(1)(A)(ii), does not fit the definition of "malpractice" under the Indiana Medical Malpractice Act ("the Act" or "IMMA"). The IMMA defines "malpractice" as a "tort or breach of contract based on health care or professional services that were provided, or that should have been provided, by a health care provider to a patient." Ind. Code § 34-18-2-18. "Health care" is defined as an "act or treatment performed or furnished, or that should have been performed or furnished, by a health care provider for, to, or on behalf of a patient during the patient's medical care, treatment, or confinement." I.C. § 34-18-2-13. "To fall outside the Act a health care provider's actions must be demonstrably unrelated to the promotion of the plaintiff's health or an exercise of the provider's professional expertise, skill, or judgment." *Howard Reg'l Health Sys. v. Gordon*, 952 N.E.2d 182, 186 (Ind. 2011). By definition, intentional chemical restraint of a nursing home resident *for the purpose convenience*, 42 U.S.C. § 1396(r)(c)(1)(A)(ii), is demonstrably unrelated to the promotion of [their] health or an exercise of the provider's professional expertise, skill, or judgment." *Ibid.* If Talevski's claim was instead that he was *negligently* prescribed or administered psychotropic medication, it would fit within the IMMA. It does not.

Determining whether Talevski was intentionally chemically restrained for the purpose of convenience, in violation of 42 U.S.C. § 1396(r)(c)(1)(A)(ii) is "not so 'vague and amorphous' that its enforcement would strain judicial competence" as Petitioners' contend (Br. 44-46). The implementing regulation for the foregoing right is 42 C.F.R. § 483.10(e)(1) which says, **"[t]he resident has a right to be treated with respect and dignity, including: the right to be free from** any physical or **chemical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with § 483.12(a)(2).**" That section says, in part:

> [T]he facility must- (2) [e]nsure that the resident is free from physical or chemical restraints not imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

42 U.S.C. § 483.12(a)(2).

The resident's **right** and the facility's **obligation** are explicit. It is not vague and amorphous, nor will it strain judicial competence to decide. It does not require a determination of "whether a given facility had done enough to "protect and promote the supposed chemical restraint right" as Petitioners claim (Br. at 45-46). The determination is made by speaking to the resident's care providers and reviewing the facility's records. The

trier of fact is not charged with determining *whether the medication was necessary*, he or she determines *whether the right has been violated*. Whether Talevski's medication was necessary is relevant to that, and—like in all cases involving an element requiring a medical opinion—treating providers and/or expert witnesses provide that evidence to the trier of fact. **The existence of a medical question does not convert a case into medical malpractice**. Most cases involving injury require medical expert testimony.

By choosing to pursue a rights violation under Section 1983 rather than a medical malpractice action, Indiana residents' claims are subjected to a higher burden of proof—intentional conduct—and a different scope of inquiry. A medical review panel is not equipped to opine on whether a nursing home corporation intentionally chemically restrained its resident, or for what reason. That question is not within the panel's purview. Section 1983 enforcement of FNHRA is necessary *because nursing home claims are not one-size-fits-all.*

What constitutes a residents' rights violation may not be medical malpractice and vice versa. Indiana medical malpractice law coexists with other claims against healthcare providers.[14] Not every negligent act or omission by a health care provider constitutes medical malpractice. *Methodist Hospital of Indiana v. Ray,* 551 N.E.2d 463 (Ind. Ct. App. 1990), *summarily aff'd on transfer,* 558 N.E.2d 829 (Ind. 1990); *Putnam Cty. Hosp. v. Sells,* 619 N.E.2d 968,970 (Ind. Ct. App. 1993). Similarly, a mere connection with a healthcare provider, or the provision

14. General Negligence claims are outside the scope of the Act. I.C. § 34-18-8-1.

of care to a patient does not necessarily bring a claim within the Act. *See e.g. Pluard ex rel. Pluard v. Patients Compensation Fund,* 705 N.E.2d 1035 (Ind. Ct. App. 1999), *trans. denied,* (surgical lamp positioned over the patient by janitorial staff becoming detached and falling on the patient was outside the Act), *Ray,* 558 N.E.2d 829 (hospital's negligence in allowing the hospital to become infested with the deadly Legionnaire's Pneumonia Virus was outside the Act). Access to various causes of action is necessary to address the myriad of harms that can occur in a nursing home.

B. Indiana medical malpractice law does not adequately address nursing home claims.

Preserving nursing home residents' ability to enforce their residents' rights under FNHRA via Section 1983 claims fills a crucial void in Indiana. Without this private right of action, based on the nature of the underlying claim, the Indiana Medical Malpractice Act (IMMA) (Ind. Code § 34-18 (2021) *et. seq.*), the Indiana Tort Claims Act (ITCA) (Ind. Code § 34-13-3 *et. seq.*), and/or the Indiana Adult Wrongful Death Act (AWDA) (Ind. Code § 34-23-1-2 (2021)), may apply to thwart a nursing home resident's attempt to be made whole after being injured by a rights violation.[15]

The IMMA and the ITCA both:

(1) shorten the common law statute of limitations for personal injury claims; (Ind.

15. The ITCA applies to a county-owned nursing home unless it is a "qualified healthcare provider" (QHP) under the IMMA. If it is a QHP, then the IMMA applies instead. This section focuses on the IMMA because most nursing home entities are QHPs.

> Code § 34-18-7-1(a)-(b), -2 (filing deadline is 2 years after the date of negligent act or omission regardless of age or legal disability, except that children less than 6 years old have until their 8th birthday to file) and Ind. Code § 34-13-3-8 (claim against political subdivision is barred unless notice provided within 180 days of the loss);
>
> **(2) proscribe administrative procedures that must be exhausted prior to commencing a claim in court**; Ind. Code § 34-18-8-4 (requiring presentation to medical review panel and receipt of panel opinion) and Ind. Code § 34-13-3-13 (requiring denial of claim by government entity before filing suit);
>
> **(3) bar claims based on any degree of contributory negligence** (qualified healthcare providers and political subdivisions are the only two exceptions to Indiana's Comparative Fault statute). Ind. Code § 34-51-2-1 and -2; *see, McSwane v. Bloomington Hosp.,* 916 N.E.2d 906, 911 (Ind. 2009)("A plaintiff's contributory negligence acts as a complete bar to recovery.") (internal citation omitted).

Finally, the IMMA (Ind. Code § 34-18-14-3 and -4), the ITCA (Ind. Code § 34-13-3-4) and the AWDA (Ind. Code § 34-23-1-2(c)-(i)) all **severely and arbitrarily limit damage awards**.

1. Statute of Limitations distinctions.

Without a private right of action under Section 1983, residents are often forced to convert their rights

violation claim into a poorly suited medical malpractice action. Among other problems, Indiana's procedural requirements for medical malpractice claims do not bode well for the elderly or infirm. First, the IMMA's absence of a tolling provision for incapacitated claimants works against nursing home residents who suffer from cognitive impairments. Ind. Code § 34-18-7-1 and (2). Indiana's statute of limitations applicable to personal injury claims, which Section 1983 claims borrow, does include tolling for legal disabilities. Ind. Code § 34-11-6-1 (2021).

Indeed, Petitioners argued below that the IMMA's exception to the tolling rule should apply to bar Talevski's Section 1983 claims. *Talevski v. Health and Hosp. Corp. of Marion Co., et. al.,* 6 F.4th 718, *721-723 (7th Cir. July 27, 2021), *cert. granted by Health and Hosp. Corp. v. Talevski,* 2022 U.S. LEXIS 2242 (U.S. May 2, 2022). The court of appeals correctly held that "a section 1983 action is not a medical malpractice action." *Id.* at *723. It further held, consistent with *Wilson v. Garcia,* 471 U.S. 261 (1985), "1983 claims are best characterized as personal injury actions" and "absent a tolling rule designed *specifically* for general personal injury claims . . . the process of deciding which state tolling rules to apply involves the straightforward application of the rules as written." *Dixon v. Charns*, 986 F.2d 201, 203-204 (7th Cir. 1993)(emphasis in original).

Talevski, like many nursing home residents, was likely "under legal disability," when his nursing home claim accrued, which Indiana law defines, in part, as "persons . . . mentally incompetent." Ind. Code § 1-1-4-5 (24) (2022). "Mentally incompetent" means of unsound mind. Ind. Code § 1-1-4-5 (12) (2022). If so, the statute

of limitations for his Section 1983 claim (borrowed from the general personal injury statute) is two years after his disability is removed. Ind. Code § 34-11-6-1. If he was under a legal disability until his death, then his disability was not "removed" until he died, and his claim survives for two years from that date. The tolling provision is necessary to address the likelihood that a resident's disability may prevent them from recognizing the federal rights violation gave rise to a legal claim, or that their rights have been violated at all. This is consistent with 42 U.S.C. § 1396r(c)(1)(C) which provides, in part, that "[i]n the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this subchapter shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf." Thus, Section 1983 relief allows for the requisite tolling exception intended to protect disabled adults that the IMMA does not.

2. Procedural hurdles.

Next, the IMMA's rigorous requirements—which amount to a mini-trial on liability—take an average of 12-24 months to complete. Then, when the claim can finally be pursued in state court, evidence and witnesses created by the administrative process may be admissible at trial, unnecessarily complicating the underlying issues. For a sick, injured, and aging adult, their chance of surviving to benefit from proceeds or to use them in pursuit of meaningful recovery, is fraught with uncertainty, frustration, and delay.

Claims against a Qualified Healthcare Providers (QHPs) in Indiana, which includes Petitioners and most nursing home entities) may not be commenced in a court in Indiana before: (1) the claimant's proposed complaint has been presented to a medical review panel . . . ; and (2) an opinion is given by the panel. Ind. Code § 34-18-8-4 (2021). The establishment, formation, members, panel selection, timeline, duties, and other parameters are set by Ind. Code. § 34-18-10, *et. seq.* (2021). The panel has the sole duty to express the panel's expert opinion as to whether or not the evidence supports the conclusion that the defendant or defendants acted or failed to act within the appropriate standards of care as charged in the complaint. Ind. Code § 34-18-10-22(a) (2021).

Medical review panels are not well-equipped to evaluate problems in nursing homes. The medical review panel is comprised of one attorney chairperson and three healthcare providers. Ind. Code § 34-18-10-3. If there is an individual defendant in the claim, two of the panelists will be members of the individual defendant's professional or specialty. Ind. Code § 34-18-10-8 (2021). This makes sense in a case where a radiologist failed to identify a suspicious mass that led to a delayed cancer diagnosis. There, at least two of the panelists would be radiologists who possessed the requisite education, training, and experience to evaluate whether the defendant met the standard of care. It does not make sense in a case where systemic, intentional—and usually corporate—misconduct led to injury of a nursing home resident. Nursing home administrators are not eligible to act as medical review panelists Ind. Code § 34-18-10-5 (2021). Thus, decisions of whether a nursing home met the standard of care are often left to healthcare providers who are highly skilled in their

areas of expertise but are understandably clueless when it comes to the minutia of federal and state requirements of nursing home operation.

Without a Section 1983 private right of action, nursing home residents are left to argue to the medical review panel that the facility's failure to comply with various sub-parts of FNHRA and its implementing regulations are evidence the providers breached the standard of care. Interestingly, the facility's attorneys will often argue that this is improper "legal" argument that should not be presented to the panel and that FNHRA is not the standard of care. Evidence of a statute violation is negligence per se in Indiana, but a medical review panel is not tasked with determining whether the facility complied with applicable statutes, including FNHRA.

Practically speaking, issues frequently arise related to selection of panel members to evaluate claims against Indiana nursing homes. The industry is tight knit, with only a handful of management chains employing the work force. Nurses asked to serve on medical review panels often express hesitation and fear of retaliation or "blacklisting" if they find a nursing home breached the standard of care and harmed a resident. Historically, panels make a finding of malpractice only about 17% of the time.[16] The panel process lacks the transparency and judicial control of the courtroom. The panel proceedings are private, and attorneys for the parties cannot participate or observe. Often, the parties learn by

16. *See,* Indiana *Patient's Compensation Fund 2021 Annual Report* at 16, available at: https://www.in.gov/idoi/files/2021-Annual-Report.pdf (last accessed Sept. 20, 2022).

speaking to panelists after they've rendered their opinion that it is based on mistaken facts or presumptions of evidence that doesn't exist. It is also not uncommon that panels give providers "the benefit of the doubt" despite being instructed not to do so. The three panel members may then be called as expert witnesses in the state court case, which compounds discovery and legal issues that would not exist but for the IMMA's requirements.

3. Damage caps.

Indiana law imposes strict limitations on damages under the ITCA. Ind. Code § 34-13-3-4. Allowable damages for a single person injured by a government actor are limited to $700,000.00 Ind. Code § 34-13-3-4. Government entities and employees acting within their scope of employment are not liable for punitive damages. Ind. Code § 34-13-3-4(b).

The Indiana Adult Wrongful Death Act also includes a categorical limit on damage awards. For unmarried adult persons who die without a dependent child, the aggregate amount of damages awarded for loss of the deceased's love, care, and affection is $300,000.00. Ind. Code § 34-21-1-2(c)(3)(e). This applies without regard to the number of non-dependent children who have a claim to this element. *Ibid.* Punitive damages, and damages for the claimant's grief are not available. Ind. Code § 34-21-1-2(c)(2).

Significantly here, the Indiana Medical Malpractice Act caps the recoverable aggregate amount of both non-economic and economic damages. Ind. Code § 34-18-14-3. The amount is divided between the provider's maximum liability and the Patient Compensation Fund's

(PCF) liability. Provider maximum liability ranges from $250,000 to $500,000 depending on the date of injury. IC §34-18-14-3. The PCF's liability ranges from $1 million to $1.3 million depending on the date of injury. *Ibid*.

4. Contributory Negligence.

Qualified healthcare providers and government actors are not subject to the Indiana Comparative Fault Act. Ind. Code § 34-51-2-1 and -2. Accordingly, any negligence *at all* on the part of the plaintiff will operate as a complete bar to recovery. *see, McSwane v. Bloomington Hosp.,* 916 N.E.2d 906, 911 (Ind. 2009). This unforgiving rule blocks the courthouse doors for many nursing home residents seeking to recover from a qualified healthcare provider. For example, any documentation in their nursing home record of noncompliance or refusal of treatment could be construed as evidence of some small amount of negligence on their part. The procedural obstacles and costs associated with pursuing a medical malpractice claim are significant. A concern that contributory negligence may be asserted against the claimant can be fatal. Section 1983's burden to prove the defendant's intent may be harder to meet, but it eliminates uncertainty that a finding of contributory negligence based on some small percentage of fault by the plaintiff could bar recovery.

It is clear why Petitioners urge this Court that resident rights violations are malpractice cases. Their liability exposure depends on it.

III. FNHRA's LIMITED ADMINISTRATIVE REMEDIES DO NOT REDRESS RESIDENT HARM AND ARE NOT INCOMPATIBLE WITH INDIVIDUAL ENFORCEMENT UNDER SECTION 1983.

The administrative grievance and hearing regulations established by the Secretary under FNHRA do not provide a remedy for nursing home residents. In fact, they are not "remedies" at all. They are minimal and aimed at putting an end to ongoing statute violations. "Where legal rights have been invaded, and a federal statute provides for a general right to sue for such invasion, federal courts may use any available remedy to make good the wrong done." *Franklin v. Gwinnett Cty. Pub. Sch.*, 503 U.S. 60, 66, 112 S.Ct. 1028, 1033 (1992) (citing *Bell* v. *Hood*, 327 U.S. 678, 684, 90 L. Ed. 939, 66 S.Ct. 773 (1946)).

If FNHRA contained an "elaborate enforcement mechanism" sufficient to displace Section 1983 enforcement, then Petitioners would not be concerned with the availability of a private right of action; if the statute itself redressed harm—as Petitioners and several *amici* so urge it does—then there would be no wrongs left to right and no damages to award. Clearly that is not the case. "A disregard of the command of the statute is a wrongful act, and where it results in damage to one of the class for whose especial benefit the statute was enacted, the **right to recover the damages** from the party in default is implied." *Franklin v. Gwinnett Cty. Pub. Sch.*, 503 U.S. 60, 67-68, 112 S.Ct. 1028, 1033 (1992) (emphasis added).

The first "elaborate enforcement mechanism" Petitioners claim provided a remedy to Talevski, 42 U.S.C.

§ 1396r(c)(1)(A)(vi), is a requirement imposed upon the facility that it "must protect and promote . . . the right to voice grievances" without discrimination or reprisal for voicing grievances, and the right to the facility's prompt efforts to resolve grievances." Its enforcing regulation, 42 C.F.R. § 483.10(j)(4), only says "**the facility** must establish a grievance policy to ensure the prompt resolution of all grievances" and "[u]pon request, the provider must give a copy of the grievance policy to the resident." It goes on to set parameters for what the facility's grievance policy must include, which are nothing more than requirements that the facility otherwise comply with and facilitate the other regulations set by the Secretary. *Ibid.*

Contrary to Petitioners' assertions, at Pet. Br. 35; 40, Talevski did not "successfully invok[e] these individualized procedures" . . . "and it worked" . . . and then . . . "challenge[ ] his transfer" . . . "and w[in] again." Specifically, Petitioners are wrong to claim Talevski "objected to his medicine, but, using a grievance procedure *provided by FNHRA itself* he was able to put a stop to it." *Id.* at 35. Instead, Talevski's daughter, sought out a medical providers not affiliated with VCR who confirmed her suspicion that her father was being chemically restrained at the nursing home. Pet. App. 78a-79a. That outside medical provider tapered his medications. *Ibid.* Some time later, the state surveyor happened to be completing the annual survey of the nursing home and Talevski's family took the opportunity to report their independent discovery that the facility had overprescribed drugs to him. That report did not result in any remedial action. *Ibid.*

Next, Talevski did not "win" a transfer challenge before an administrative law judge of the ISDH, "entitling

him . . . to return to VCR [had he chosen to do so]." Pet. Br. at 40. Instead, after a six hours long hearing, the ALJ determined that "the decision to transfer Talevski from VCR should not be affirmed." Pet. App. 80a. At this point, he had been admitted to another facility while the administrative proceeding occurred. *Ibid.* The final order of the ALJ issued after the appeal period closed. Talevski's family attempted to have him return to VCR. *Ibid.* VCR ignored the order. Pet. App. 81a. Talevski's family made a complaint to ISDH regarding VCR's refusal to abide by the ALJ's order. Four months had passed since the wrongful discharge and three months since the ALJ's order when VCR contacted the Talevskis "to discuss evaluating [him] for return to VCR." Pet. App. 81a. Talevski had been displaced three hours away for months at that point and the family's trust in the facility was broken. *Ibid.* Returning him to Petitioners' care would not have been "remedial" at that time. Clearly, the "administrative remedies" provide a fundamentally different type of relief than a private right of action under Section 1983. For Talevski, they were not remedial. "The performance of the act must rest somewhere, or it will present a case which has often been said to involve a monstrous absurdity in a well organized government, that there should be no remedy, although a clear and undeniable right should be shown to exist." *Franklin v. Gwinnett Cty. Pub. Sch.*, 503 U.S. 60, 67, 112 S.Ct. 1028, 1033 (1992) (internal quotation omitted).

FNHRA's measures are also not "incompatible" with individual enforcement under Section 1983—or any other federal, state, or common law remedy. As Petitioners' Indemnity Agreement confirms, those claims can coexist. *Burkhart, supra.,* at 8; 25-26. It is telling that many states

have codified FNHRA into state law and provided for a private cause of action, treble damages, and/or attorney fee awards for violations. This alone confirms both (1) that FNHRA's administrative remedies are insufficient to compensate for rights violations and (2) that they are not incompatible with private causes of action for enforcement of resident rights.

It is clear HHC's decision to keep supplemental funding for other purposes, and ASC's continued ability to turn a profit, came at the expense of funding resident care at their facilities. Residents were thereby deprived of their rights, guaranteed by 42 U.S.C. § 1396r, *et. seq.*, and set forth in 42 C.F.R. § 483.10, which gives rise to HHC's liability under 42 U.S. § 1983. The immorality of the HHC-ASC nursing home practice, has been explained by one bioethics professor, that "[a]s a general moral principal when dealing with vulnerable persons, your first duty is to make sure they have adequate protection and services to meet their needs." Hatcher, *supra.* at 195 (internal quotation omitted).

Petitioners could have appropriately funded their nursing homes with the billions of dollars in supplemental UPL money they've accepted and upheld their known duty not to violate Talevski's rights under FNHRA. They did not. Now, they request this Court absolve them of their known, considered, and negotiated liability risk, now and forever, so that they may continue to divert nursing home residents' Medicaid benefits—federal taxpayers' dollars—in peace.

CONCLUSION

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

Respectfully submitted.

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