No. 21-806

In The Supreme Court of the United States

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

Petitioners,

v.

IVANKA TALEVSKI, Personal Representative of the Estate of Gorgi Talevski, Deceased,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

BRIEF OF THE PENNSYLVANIA ASSOCIATION FOR JUSTICE AND THE AMERICAN ASSOCIATION FOR JUSTICE AS *AMICI CURIAE* IN SUPPORT OF THE RESPONDENT

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INTEREST OF *AMICI CURIAE*[1]

The Pennsylvania Association for Justice ("PAJ"), formerly Pennsylvania Trial Lawyers Association, is a non-profit organization with a membership of 2,000 women and men of the trial bar of the Commonwealth of Pennsylvania. For nearly 50 years, the Association has promoted the rights of individual citizens by advocating the unfettered right to trial by jury, full and just compensation for innocent victims, and the maintenance of a free and independent judiciary. Through its *Amicus Curiae* Committee, PAJ strives to maintain a high profile in Commonwealth and Federal Courts by promoting, through advocacy, the rights of individuals and the goals of its membership.

The American Association for Justice ("AAJ") is a national, voluntary bar association established in 1946 to strengthen the civil justice system, preserve the right to trial by jury, and protect access to the courts for those who have been wrongfully injured. With members in the United States, Canada, and abroad, AAJ is the world's largest plaintiff trial bar. AAJ's members primarily represent plaintiffs in personal injury actions, employment rights cases, consumer cases, and other civil actions. Throughout its more

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[1] 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.

than 75-year history, AAJ has served as a leading advocate for the right of all Americans to seek legal recourse for wrongful conduct.

In this case, AAJ and PAJ are concerned that reversal of this Court's recognition that Spending Clause statutes can secure rights pursuant to 42 U.S.C. § 1983 will deprive many vulnerable Americans of the right to a remedy intended by Congress when it passed the Federal Nursing Home Reform Act.

SUMMARY OF THE ARGUMENT

Apart from the legal arguments ably set out by Respondent, this Court may be concerned that the right of action recognized by the Seventh Circuit may be unworkable or give rise to an unmanageable "flood" of claims. Indeed, *amici* supporting Petitioners explicitly make the argument that, while "State and local governments are among the most important providers of nursing home facilities in the country," Brief of the National Conference of State Legislatures, et al. as *Amici Curiae* in Support of Petitioners 11, "creating a private FNHRA action under Section 1983 would create a disincentive for States and local governments to continue operating nursing homes." *Id*. at 10.

Pennsylvania counties own and operate 19 skilled nursing facilities. For more than a decade following the Third Circuit's decision in *Grammer v. John J. Kane Reg'l Ctrs. – Glen Hazel*, 570 F.3d 520 (3d Cir. 2009),

nursing homes owned by Pennsylvania counties have operated subject to section 1983 liability for violation of the Federal Nursing Home Reform Act of 1987. None of the dire predictions of Petitioners and their supporting *amici* have even remotely come to pass.

Indeed, *Grammer* itself only came to be because of Pennsylvania's statutory immunity scheme – which is comprised of two separate statutes, one geared towards Commonwealth entities and one geared towards local agencies, including Counties. While similar, there is one important difference between the two statutes – there is no immunity exception for medical or professional negligence against County-owned health care facilities, including nursing homes. Simply put, this means:

- Residents of Commonwealth-run nursing facilities can pursue state law negligence claims for poor medical or nursing care.
- Residents of Commonwealth hospitals can state law pursue negligence claims for poor medical or nursing care.
- Prisoners incarcerated in Commonwealth prisons can pursue state law negligence claims for poor medical or nursing care.
- Residents of County-run nursing homes have ***no state law recourse for poor medical or nursing care.***

At best, *Grammer* provides a narrow and limited cause of action for residents of County-run nursing homes in Pennsylvania and elsewhere. In

Pennsylvania, however, a limited, narrow cause of action is better than no legal recourse at all. Further, *Grammer* was correctly decided and the standards set forth therein have proven workable and Courts have had no difficulty managing these types of cases. Importantly, if applied by its terms, *Grammer* also opens the courthouse doors to some of society's most vulnerable adults, those residing in County-owned nursing facilities.

Finally, arguments made by Petitioners, and by the United States as *Amicus Curiae* in Support of Neither Party, that the FNHRA provides a comprehensive enforcement scheme are also incorrect. Apart from the fact that none of the enforcement mechanisms within the FNHRA are directed at or provide compensation to residents of nursing facilities, data from both the Center for Medicaid and Medicare Services ("CMS") and the Pennsylvania Department of Health ("DOH") shows that that enforcement mechanisms within the FNHRA, while perhaps robust on the surface, are in practice, decidedly less so.

ARGUMENT

I. SOVEREIGN IMMUNITY IN PENNSYLVANIA.

A. PENNSYLVANIA'S DUAL IMMUNITY STATUTES.

The Constitution of the Commonwealth of Pennsylvania provides:

> Suits may be brought against the Commonwealth in such manner, in such courts and in such cases as the Legislature may by law direct.

PA. CONST., ART. I, SECTION 11.

In furtherance of this Constitutional provision, the Pennsylvania General Assembly has waived sovereign immunity for certain categories of claims against the Commonwealth and its agencies within the Pennsylvania Sovereign Immunity Act ("PSIA"), specifically at 42 Pa.C.S. § 8522. That section includes waiver of immunity, thereby permitting negligence claims in the following circumstances: 1) vehicle liability; 2) medical professional liability; 3) liability related to care, custody or control of personal property; 4) defects in Commonwealth real estate, highways and sidewalks; 5) liability concerning potholes and other dangerous conditions; 6) care, custody or control of animals; 7) liquor store sales; 8) National Guard activities; 9) liability related to toxoids and vaccines administered by Commonwealth parties; and 10) claims related to sexual abuse.

The General Assembly, in a separate immunity act, has also waived sovereign immunity for actions against local agencies (including as applicable here, Pennsylvania Counties) within the Political Subdivision Tort Claims Act ("PSTCA"), specifically at 42 Pa.C.S. § 8542. That section includes waiver of immunity, thereby permitting negligence claims in the following circumstances: 1) vehicle liability; 2) claims related

to care, custody or control of personal property; 3) liability related to real property; 4) liability related to trees, traffic controls and street lighting; 5) liability related to utility services; 6) defects in local agency streets; 7) defect in local agency sidewalks; 8) issues relating to care, custody or control of animals; and 9) claims related to sexual abuse.

The dual acts, while similar, preclude the filing of any type of negligence action by a resident against a County-owned skilled nursing facility.

B. A COMPARISON OF THE IMMUNITY ACTS.

A comparison of the PSIA alongside the PSTCA shows that in general, there is logic to the dual acts. Initially, many of the same exceptions apply under either the PSIA or the PSTCA – in particular these exceptions govern conduct that is common to both Commonwealth and local agency actors. Those exceptions include:

1. Vehicle Liability, 42 Pa.C.S. § 8522(b)(1); 42 Pa.C.S. § 8542(b)(1);
2. Personal Property, 42 Pa.C.S. § 8522(b)(3); 42 Pa.C.S. § 8542(b)(2);
3. Real property, roads/streets, sidewalks, potholes, 42 Pa.C.S. § 8522(b)(4); 42 Pa.C.S. § 8542(b)(3),(6),(7);
4. Control of animals; 42 Pa.C.S. § 8522(b)(6); 42 Pa.C.S. § 8542(b)(8);

5. Sexual Abuse; 42 Pa.C.S. § 8522(b)(10); 42 Pa.C.S. § 8542(b)(9);

Next, there are certain exceptions that are germane only to Commonwealth conduct, because the actions described are performed strictly by Commonwealth actors:

1. Liquor store sales, 42 Pa.C.S. § 8522(b)(7);
2. National Guard Activities, 42 Pa.C.S. § 8522(b)(8);
3. Toxoids and Vaccines, 42 Pa.C.S. § 8522(b)(9);

Finally, there is one exception applicable only to local agencies, for negligence arising from a dangerous condition of Utility Service Facilities. *See* 42 Pa.C.S. § 8542(b)(1). Ensuring Utility Service Facilities are properly maintained is strictly a local agency function in Pennsylvania.

Which leaves just one remaining exception, the "Medical/Professional Liability" exception found only in the PSIA, located at 42 Pa.C.S. § 8522(b)(3). In full, that exception reads:

> Medical-professional liability. – Acts of health care employees of Commonwealth agency medical facilities or institutions or by a Commonwealth party who is a doctor, dentist, nurse or related health care personnel.

42 Pa.C.S. § 8522(b)(3).

The medical-professional liability exception, while limited only to the actions of medical personnel employed by the Commonwealth, has been applied consistently in that regard to permit medical negligence claims, including those arising from a Commonwealth-run nursing home to move forward in Pennsylvania.

For example, claims against Commonwealth hospitals have been permitted by the Courts. *See Yellen v. Philadelphia State Hosp.*, 503 A.2d 1108 (Pa. Commw. Ct. 1986) (Exception to sovereign immunity applied in case against Commonwealth Hospital on behalf of a third party assaulted by a negligently released patient). Claims for negligent medical care of state prisoners have routinely been permitted pursuant to the medical professional liability exception as well. In *Wareham v. Jeffes*, 564 A.2d 1314 (Pa. Commw. Ct. 1989), the Commonwealth Court held not only that a prison's infirmary fits within the definition of a Commonwealth medical facility, but further determined that the chief health care administrator of the prison was in fact within the definition of "Commonwealth . . . health care personnel." *Id.* at 1323-24.

Perhaps most relevant here, claims against Commonwealth-run skilled nursing facilities are also permissible pursuant to the medical professional liability exception. In one such case, *Byrne v. Department of Military and Veteran's Affairs*, No. 561 C.D. 2018, 2019 WL 1284539 (Pa. Commw. Ct. 2019), a negligence suit against a Commonwealth-run skilled nursing facility was allowed to proceed based on allegations that an aide at the Commonwealth facility failed to monitor

residents, which permitted one resident (identified as Resident 4757) to push the Plaintiff's Decedent, Robert Beaverson, resulting in Mr. Beaverson's death. The Court reasoned:

> Assuming the allegations set forth in the Beaverson Estate's Complaint are true, the CNA and other Center staff had a duty to intervene, redirect, and/or deescalate any altercations involving Decedent, Resident 4757, or any other Center residents to prevent Decedent, Resident 4757, or any other Center residents from suffering physical harm. If the Beaverson Estate proves that the CNA had this duty and breached it, the Beaverson Estate must be given an opportunity to establish that the "acts of a health care employee" were a contributing cause to Decedent's injuries. Appellees should not be able to use sovereign immunity to avoid liability for their actions and/or inactions under these circumstances simply because Resident 4757 and not a Center health care employee pushed Decedent causing him to fall and hit his head.

Byrne, at *8.

Conversely, the lack of a medical professional liability exception with regard to counties has been clearly recognized by Pennsylvania Courts. In *Davis v. County of Westmoreland, d/b/a Westmoreland Manor*, 844 A.2d 54 (Pa. Commw. Ct. 2004), an estate's administrator brought state law survival and wrongful death cases against the County of Westmoreland related to alleged negligence that had occurred at Westmoreland

Manor, a skilled nursing facility owned and operated by the County of Westmoreland. The Commonwealth Court succinctly rejected those claims, holding:

> Medical negligence is not covered by any of the exceptions to governmental immunity provided in Section 8542 of the Code. ["the Code" references the PTSCA]. Therefore, local agencies, including counties, are immune from medical negligence liability. *Helsel v. Complete Care Servs., L.P.*, 797 A.2d 1051 (Pa.Cmwlth.2002) (a wrongful death or medical negligence action against a county facility is barred by governmental immunity); *Gill v. County of Northampton*, 88 Pa.Cmwlth. 327, 488 A.2d 1214 (1985); *Morris v. Montgomery County Geriatric and Rehab. Ctr.*, 74 Pa.Cmwlth. 363, 459 A.2d 919 (1983).

Davis, 844 A.2d at 56.

What this means, from a practical point of view, is that for Commonwealth-run nursing homes, hospitals and other medical facilities (including prisons), a cause of action for state law negligence can be brought pursuant to the medical-professional liability exception found in the PSIA. However, County-run skilled nursing facilities are completely immune from state law professional negligence claims because there is no exception that would permit those claims to move forward.

As such, in Pennsylvania, for those neglected or abused in a County-owned skilled nursing facility, the only avenue for relief are claims for deprivation of

rights secured by the FNHRA brought pursuant to 42 U.S.C. § 1983.

II. COUNTY-RUN HOMES IN PENNSYLVANIA.

Pennsylvania currently has 19 skilled nursing facilities, owned and operated by 16 separate Pennsylvania Counties. These 19 homes contain 6,524 beds. County-run homes tend to be some of the largest skilled facilities in Pennsylvania, and the 6,524 beds make up approximately 7.5% of all skilled nursing facility beds in the Commonwealth.[2]

If the Court finds in favor of the Petitioners in this case with regard to either of the questions presented, the results for residents of Pennsylvania County-run facilities would be nothing short of tragic – those residents would be left with no remedy if they were injured or died as a result of inappropriate or even callous conduct on the part of County-run facilities. This would leave residents in the inequitable and untenable position of having no means to recover for wrongs committed against residents when every other nursing home resident in Pennsylvania does have a means of redress

[2] Pennsylvania has approximately 88,000 total beds across approximately 700 facilities, which in general are approximately 91% occupied. *See* Pennsylvania Health Care Association, https://www.phca.org/for-consumers/research-data/long-term-and-post-acute-care-trends-and-statistics (last accessed on September 2, 2022); Pennsylvania Department of Health, https://www.health.pa.gov/topics/facilities/nursing%20homes/Pages/Nursing%20Homes.aspx#:~:text=A%20nursing%20home%20is%20a,nursing%20homes%20throughout%20the%20state. (last accessed on September 2, 2022).

with the Courts. Further, patients in Commonwealth hospitals and inmates in Commonwealth prisons also have the ability to seek Court intervention if they are negligently treated in a Commonwealth medical facility. It is entirely appropriate for those in prison and those in private and Commonwealth-operated skilled nursing facilities and hospitals to have access to the Courts, it is simply beyond peradventure that residents of County-owned facilities should also have rights to court access. Further, it is worth noting that preservation of FNHRA-based civil rights claims brought pursuant to 42 U.S.C. § 1983 would not place residents of Pennsylvania County-run facilities on a level playing field with Pennsylvania prisoners or residents of other Pennsylvania skilled nursing facilities. Those residents would still be unable to bring claims for negligence against a County-run facility; they would continue to be limited to pursuing only civil rights claims, and all the increased burdens that come with those types of claims.

Of course, preservation of this narrow remedy is preferable to denying elderly victims of neglect any remedy at all. As important, the ability to bring civil rights claims preserves the fundamental right to a civil trial by jury for over 6,000 of Pennsylvania's most vulnerable citizens – a right that is enshrined in both the Pennsylvania and United States Constitutions. PA. CONST., ART. I, SECTION 6 ("Trial by jury shall be as heretofore, and the right thereof remain *inviolate*.") (emphasis added); U.S. CONST. AMEND. VII ("In suits at common law, where the value in controversy shall

exceed twenty dollars, the right of trial by jury shall be preserved. . . .”). This Court should preserve those rights and affirm the Seventh Circuit decision in this case.

III. *GRAMMER* CLAIMS SHOULD BE PRESERVED AS THEY PROVIDE THE ONLY MEANS OF COURT ACCESS TO RESIDENTS OF PENNSYLVANIA COUNTY-RUN HOMES.

A. THROUGH A FAITHFUL APPLICATION OF SUPREME COURT PRECEDENT, THE *GRAMMER* DECISION OPENED THE COURTROOM DOORS TO RESIDENTS OF COUNTY-OWNED NURSING HOMES.

In 2009, Melvinteen Daniels, a mother of eight, was admitted to John J. Kane Regional Centers – Glen Hazel, a County-run nursing home outside of Pittsburgh. Mrs. Daniels was 80 years old and required skilled nursing care because of dementia. While at Kane, she developed a decubitus ulcer, colloquially known as a “bedsore.” In order to prevent skin breakdown in the elderly, nursing staff must make sure that residents are turned and repositioned in bed or in their chair at least every two hours. Mrs. Daniels’ bedsore became so severe that it became infected and foul-smelling. She was admitted to the hospital, where she was diagnosed with life-threatening septic shock. She required multiple surgeries to debride areas of necrosis from her wounds. The hospital discovered two

additional bedsores on Mrs. Daniels' heels. At one point, Mrs. Daniels' sacral decubitus ulcer measured 10.9 x 7.02 inches. *Grammer v. Kane*, 2:06-cv-00781 (U.S.D.C. W.D. Pa.), Complaint, ECF Document 1. Mrs. Daniels also became severely malnourished at Kane nursing home. Mrs. Daniels died from these injuries.

Her family sought to hold Kane accountable. But with the Political Subdivision Tort Claims Act prohibiting any common law negligence claim, it seemed that the Daniels family had no legal recourse. Sarah Grammer, Ms. Daniels' daughter, then ventured down a road yet unpaved in Pennsylvania – she sued Kane nursing home in Federal Court for violations of the Federal Nursing Home Reform Act's Bill of Rights, which she sought to enforce pursuant to § 1983. Sarah Grammer alleged that Kane had violated, among other things, her mother's rights to care that promoted maintenance and enhancement of her life; care in a manner and environment that maintained and enhanced her dignity; her right to proper nutrition; and her right to be free from chemical restraint. *See* Complaint, *supra*.

The Western District of Pennsylvania dismissed Grammer's holding that the Federal Nursing Home Reform Act merely set forth requirements a nursing facility must comply with to receive federal Medicaid funds, but did not create rights enforceable under § 1983.

On appeal, the question framed for the Third Circuit was identical to that which this Court now considers: Whether provisions of the "Residents Rights"

section of the FNHRA give Medicaid recipients rights whose violation can be remedied under § 1983. *Grammer v. John J. Kane Reg'l Centers-Glen Hazel*, 570 F.3d 520, 525 (3d Cir. 2009).

The Third Circuit started by recounting the history of the Federal Nursing Home Reform Act:

> Before Congress amended the Medicare and Medicaid Acts in 1987, only two sanctions were available against nursing homes for noncompliance with federal participation requirements. First, the Secretary of Health and Human Services or the states themselves could decertify the facility and terminate the nursing home's eligibility to receive Medicaid reimbursements. Second, if noncompliance was not an immediate and serious threat to the residents' health and safety, the Secretary or the states could deny payment for new admissions for up to eleven months. These sanctions were rarely invoked.
>
> As a result, the programs permitted too many substandard nursing homes to continue operations. Congress thus became "deeply troubled that the Federal Government, through the Medicaid program, continue[d] to pay nursing facilities for providing poor quality care to vulnerable elderly and disabled beneficiaries." H.R.Rep. No. 100–391, at 471 (1987), reprinted in 1987 U.S.C.C.A.N. 2313–1, 2313–272.

Id. at 523.

Nursing homes were not holding up their end of the bargain. So in 1987, Congress decided to act. Congress passed the Federal Nursing Home Reform Act as one bill within the Omnibus Budget Reconciliation Act of that year. Under the FNHRA, nursing homes wishing to participate in the Medicaid and Medicare programs would need to satisfy conditions of participation in areas such as "quality of care" and "residents rights." *See* 42 U.S.C. § 1396r. Now, Sarah Grammer was seeking to enforce violations of those "residents rights" through § 1983.

The *Grammer* court began its analysis with the concept that even when a federal law does not expressly authorize a private cause of action it may do so through § 1983 by creating rights, and that actions for deprivations of rights arising from federal law pursuant to 42 U.S.C. § 1983 are "presumptively available against individuals acting under color of state law." *Grammer*, 570 F.3d at 525, citing *Livadas v. Bradshaw*, 512 U.S. 107 (1994).

The Third Circuit then applied this Court's three-prong test set out in *Blessing v. Freestone*, 520 U.S. 329, 340 (1997). First, the Third Circuit held, "there is no question that the statutory provisions under which Grammer raises her claims meet the first *Blessing* factor. As both a Medicaid recipient and a nursing home resident, Grammer's mother was an intended beneficiary of 42 U.S.C. § 1396r." *Grammer*, 570 F.3d at 527. The Third Circuit reached this conclusion from the text of Section 1396r and its accompanying regulations, which require nursing facilities "to provide . . .

specialized rehabilitative services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident." *Id*. "Unlike the statutes at issue in *Gonzaga Univ*. and *Blessing,*" the court commented, "the FNHRA are directly concerned with 'whether the needs of any particular person have been satisfied'." *Id*. (citing *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002)). Unlike the statute at issue in *Blessing*, which was a "yardstick for the Secretary to measure . . . systemwide performance" of a state program, here the FNHRA's concern was "whether each individual placed in nursing home receives proper care." *Id*. at 527-28 (internal citations omitted).

Blessings's second prong is also met. The Third Circuit did not believe that the rights which Sarah Grammer sought to enforce, including phrases "must provide," "must maintain," and "must conduct," were so "vague or amorphous" that the judiciary was incapable of interpreting and enforcing them. *Id.* at 528.

Finally, the *Grammer* court concluded that the language of the FNHRA's resident rights provisions unambiguously binds the states and the nursing homes. This was indicated by the repeated use, within these sections, of the word "must." The court recognized that "this language is mandatory in nature and easily satisfies the third factor of the *Blessing* test." *Id*.

Having completed the analysis of the *Blessing* factors, the court then turned to *Gonzaga*, to ensure there was sufficient "rights-creating language" within the FNHRA. The court observed:

> The FNHRA are replete with rights-creating language. The amendments confer upon residents of such facilities the right to choose their personal attending physicians, to be fully informed about and to participate in care and treatment, to be free from physical or mental abuse, to voice grievances and to enjoy privacy and confidentiality. 42 U.S.C. § 1396r(c)(l)(A). Nursing homes are required to care for residents in a manner promoting quality of life, provide services and activities to maintain the highest practicable physical, mental and psychosocial well-being of residents, and conduct comprehensive assessments of their functional abilities. 42 U.S.C. § 1396r(b)(l), (2) & (3). Further, the statute specifically guarantees nursing home residents the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat their medical symptoms. 42 U.S.C. § 1396r(l)(A)(ii).

Id. at 529.

The text of the FNHRA supports that Congress intended for it to be rights-creating. So did the legislative history. In 1987, when Congress passed the FNHRA, the report from the House of Representatives began with commentary about how nursing homes were not meeting the needs of developmentally disabled residents. H.R.Rep. No. 100–391, pt. 1, at 459, reprinted in

1987 U.S.C.C.A.N. 2313–279. The FNHRA was the solution to this problem.

In sum, the *Grammer* court held, "it is clear enough that Congress intended to create individual rights in drafting and adopting § 1396r, and that [Sarah Grammer's] mother falls squarely within the zone of interest these provisions are meant to protect. Hence, we hold that the statutory provisions which Grammer seeks to enforce under § 1983 satisfy both *Gonzaga Univ.'s* insistence on rights-creating language as evidence of Congressional intent and *Blessing's* remaining factors." *Id*. at 532.

IV. IN PRACTICE, *GRAMMER* HAS PROVEN WORKABLE AND MANAGEABLE.

While the Petitioners and supporting *amici* argue that the standards to secure rights under the FNHRA are not workable, *see*, *e.g.*, Brief for Petitioners 25-26; Brief of the National Conference of State Legislatures, *et al.* as *Amici Curiae* In Support of Petitioners 9-11, actual practice in Pennsylvania has proven otherwise. Since the *Grammer* decision in 2009, a review of the dockets in Pennsylvania shows that Courts have no issue handling and resolving these cases.[3]

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[3] An appendix listing 44 cases filed since (or just before) the *Grammer* decision is attached as Appendix 2. Because searching online dockets and legal research sites can be inexact when there are currently 19 different County defendants (and more in prior years), while it is likely that the 44 cases listed do not make up the entire universe of all cases filed in Pennsylvania since the *Grammer* decision, they do form a representative sample and

Initially, as seen in Appendix 2, because of the nature of a civil rights action brought pursuant to 42 U.S.C. § 1983, and the exacting standards required to plead and prove such a claim, there have simply not been many of these types of cases filed. Understanding that the 44 cases collected represent a substantial majority of cases brought to enforce rights guaranteed by the FHNRA, the data shows that no more than 2 or 3 of these cases are filed in Pennsylvania on average in any given year.

Further, Courts have encountered no particular difficulty handling these cases. As Appendix 2 shows, a summary of the status of these cases is as follows:

Settled – No Motion to Dismiss, no discovery:	9
Settled – *Grammer* and immediately following:	4
Settled – during or immediately after discovery: (In eight, Motions to Dismiss were denied or resulted in an Amended Complaint)	19
Ongoing (Three of six have had Motions to Dismiss resolved):	6
Motion to Dismiss Granted (One of which was affirmed by Third Circuit)	2
Summary Judgment granted:	3
Trial (Defense verdict / On Appeal):	1

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certainly include a substantial majority of all cases filed in Pennsylvania.

As can be seen, like civil cases generally, the majority of the FHNRA enforcement cases resolved since *Grammer*, have resolved via settlement. Within the 32 settled cases, nine settled before any motions practice, 19 settled during or immediately after discovery. The other four were pending when *Grammer* was decided and settled shortly thereafter.

Additionally, five of the cases have been dismissed – two via a Motion to Dismiss or and three via Summary Judgment. There has been one trial, which resulted in a defense verdict, which is pending on appeal to the Third Circuit. Finally, six cases remain ongoing, with plaintiffs in three of those having overcome a Motion to Dismiss.

What do these statistics show about the workability and manageability of these cases? Quite simply, Pennsylvania's experience has been that cases brought pursuant to *Grammer* proceed like any other civil case. Most are settled, some are dismissed via dispositive motions practice, and few are tried. These results indicate that Courts have absolutely no difficulty with workability or manageability of these types of cases, and any concerns in that regard are simply incorrect.

Nor has *Grammer* opened floodgates of nursing home litigation in federal court. This is largely because the standards required to maintain a § 1983 claim are a much higher hurdle than a garden variety state law negligence claim. Under Pennsylvania state law, a plaintiff pleads a viable professional negligence claim if they allege sufficient facts to support the traditional

elements of duty, breach of duty, causation, and damages. In an ordinary negligence claim it is enough for the resident to show that her nursing home failed to exercise reasonable care, or employed an individual who failed to exercise reasonable care. *See Toogood v. Rogal*, 824 A.2d 1140 (Pa. 2003).

Trial and appellate courts have required a much greater showing to maintain a *Grammer* claim. Unlike an ordinary state law claim, courts have required *Grammer* plaintiffs to show that the violation of the plaintiff's rights was caused by action taken pursuant to a policy or custom or by the deliberate indifference of a policymaker. *See*, *e.g.*, *Tammaro v. Cnty. of Chester, Pocopson Home*, No. CV 21-3811, 2022 WL 468192, at *2 (E.D. Pa. Feb. 16, 2022); *Alexander v. Fair Acres Geriatric Ctr.*, No. CV 20-2550, 2021 WL 2138794, at *3 (E.D. Pa. May 26, 2021); *see also Robinson v. Fair Acres Geriatric Ctr.*, 722 F. App'x 194, 200 (3d Cir. 2018) (unpublished opinion). Plaintiffs have not always been able to meet these heightened standards. *See Schlaybach v. Berks Heim Nursing & Rehab.*, 839 F. App'x 759, 761 (3d Cir. 2021) (affirming dismissal of plaintiff's *Grammer* claim for failure to plead sufficient facts to support the claim).[4]

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[4] *Grammer* cases in practice, show that these type of cases in no way "federalize[d] medical malpractice law" or "sweep[ ] aside carefully chosen state policies in favor of a one-size fits all resort to Section 1983" as Petitioners contend. Pet'n at 9. Instead, the Pennsylvania experience shows that even in a state whose immunity laws prohibit "medical negligence" cases against County-run facilities, these cases are infrequently filed. In states where state law claims are available against County-run facilities, these

The harms these cases seek to remedy are varied and important – particularly since those who are injured or those who have died represent the most vulnerable Pennsylvanians, elderly individuals residing in skilled nursing facilities. By way of limited example, as referenced above, the decedent in the *Grammer* case, Melvinteen Daniels, suffered serious decubitus (pressure ulcers), malnutrition and dehydration. Mrs. Daniels developed infections, became septic and died as a result. *See Grammer v. Kane*, 570 F.3d at 522. These cases have also addressed and alleged other serious issues, including the failure to follow advance directives resulting in a failure to attempt resuscitation leading to death, *see Quinlan v. Kane*, 2:04-cv-0485 (U.S.D.C. W.D. Pa.), ECF Document 1; the failure to prevent falls leading to over 15 separate bone fractures and death, *see Carlson v. Kane*, 2:13-cv-01086 (U.S.D.C. W.D. Pa.), ECF Document 1; and allowing a resident to die of profound dehydration. *See Toth v. Kane*, 2:15-cv-00946 (U.S.D.C. W.D. Pa.), ECF Document 1.

In sum, cases brought to enforce rights of residents of skilled nursing facilities secured by the FNHRA present no particular issues for the courts. These cases are filed infrequently and proceed like any other civil cases – with settlements, motions-based dismissals and, rarely, with trial. When seen in perspective with the case results and with the harms these

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cases will logically be filed even less frequently, and then only in the most egregious of cases. Rather than "sweeping aside" state law, these civil rights cases complement state law protections.

cases seek to remedy, harms suffered by the most vulnerable residents of society, any argument that the standards are not workable is simply wrong. In practice, *Grammer*-based § 1983 claims are working and serving the intended purpose of the FNHRA. Petitioners have presented no persuasive support for their argument that affirmance of the Seventh Circuit's decision in this case would lead to a less desirable outcome.

V. THE FNHRA'S ENFORCEMENT SCHEME IS NOT ADEQUATE OR COMPREHENSIVE.

Petitioners contend, along with the United States of America, that the individual rights created by the FNHRA are accompanied by a "comprehensive enforcement scheme" wherein entities within each state responsible for the distribution of Medicare and Medicaid funds are likewise empowered to enforce the rights guaranteed under the FNHRA. Brief for Petitioners 39. They further contend, that even if individual rights are created by the FNHRA, this enforcement scheme prevents resort to 42 U.S.C. § 1983. *Id*. *See also* Brief for the United States as *Amicus Curiae* Supporting Neither Party 30-33.

In this regard, 42 U.S.C. § 1396r(h)[5] requires each State that participates in the Medicaid program to

[5] Importantly, neither the Petitioners or the United States point to this section of the remedial scheme – and with good reason, because these sorts of generalized enforcement mechanisms have never been found to implicitly preclude access to 42 U.S.C. § 1983. But even if the Court was included to take these sections into account in its analysis, it is worth noting how ineffective they are in practice.

establish specific remedies either through regulations or law. Title 42 U.S.C. § 1396r(h)(2) specifically addresses enforcement sanctions and reads in relevant part[6]:

> **(2) Specified remedies**
>
> **(A) Listing**
>
> Except as provided in subparagraph (B)(ii), each State shall establish by law (whether statute or regulation) at least the following remedies:
>
> **(i)** Denial of payment under the State plan with respect to any individual admitted to the nursing facility involved after such notice to the public and to the facility as may be provided for by the State.
>
> **(ii)** A civil money penalty assessed and collected, with interest, for each day in which the facility is or was out of compliance with a requirement of subsection (b), (c), or (d). . . .
>
> **(iii)** The appointment of temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while –

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[6] Enforcement, and sanctions, if applicable, follows a survey conducted by a state agency which in most instances, including the Commonwealth of Pennsylvania, is the Department of Health. There are various types of surveys conducted, including annual, extended and complaint based. *See* 42 U.S.C. § 1396r(g).

> **(I)** there is an orderly closure of the facility, or
>
> **(II)** improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).
>
> The temporary management under this clause shall not be terminated under subclause (II) until the State has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).
>
> **(iv)** The authority, in the case of an emergency, to close the facility, to transfer residents in that facility to other facilities, or both.

The above penalties, for violation of Medicaid standards of participation, are similar, though not identical, to those found at 42 U.S.C. § 1395i-3(h).[7] Though this case specifically involves the sanctions found in 42 U.S.C. § 1396r, even when taken in conjunction with the similar sanctions found in 42 U.S.C. § 1395i-3, these measures do not provide an adequate, let alone comprehensive, enforcement scheme. As will be seen, not only are these sanctions directed at skilled nursing facility performance generally, they clearly do

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[7] That statutory section covers surveys and penalties related to violations of Medicare standards of participation and empowers the Secretary to also levy sanctions practically identical to those set forth in 42 U.S.C. § 1396r.

not allow an individual resident to enforce the deprivations of rights guaranteed that resident by the FNHRA.

The available sanctions, on paper, may seem varied and in some instances severe. In essence, the individual States and/or Secretary of the Department of HHS can statutorily: 1) impose a civil penalty; 2) deny Medicare or Medicaid payments; 3) appoint temporary management; or 4) close the facility in case of an emergency. However, in practice the vast majority of sanctions issued are nothing more than small civil penalties.

A. CMS ENFORCEMENT IN PENNSYLVANIA.

For example, in Pennsylvania, between 2019 and 2022, CMS issued 1,110 sanctions. However, only 42 included denial of payments from the Medicare or Medicaid programs. Those denials averaged only 39 days, and the median civil penalty was approximately $3,250.00, while the average civil penalty was $13,137.33.[8]

Data on other remedies imposed by CMS is less recent, but this data shows that between 2006 and 2014, although 725 enforcement actions were taken

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[8] *See* Centers for Medicare and Medicaid Services penalty data, available at https://data.cms.gov/provider-data/search?theme=Nursing%20homes%20including%20rehab%20services, last accessed on August 30, 2022. (Hereinafter "CMS 2019-2022 Penalty Data.").

across all Pennsylvania facilities (an average of 715 facilities per year), there were only two facility closures ordered and four mandatory terminations ordered in the Commonwealth of Pennsylvania. Conversely, there were 439 civil penalties issued and 167 directives to complete in-service training, which comes with no monetary penalty at all.[9]

B. CMS ENFORCEMENT NATIONALLY.

Nationally, this trend toward minor actions and away from more serious actions continued, with only 6.8% of 33,772 penalties issued by CMS being denial of payments, usually for an average of 31 days. The median fine amount from this set of national data was again only $3,250.00 and averaged approximately $14,000.00. *See* CMS 2019-2022 Penalty Data.

Meanwhile, from 2006 to 2014 CMS detailed 36,456 enforcement remedies across the nation, with 21,233 of these being monetary penalties. By comparison, over that same time period, nationally there were only 144 mandatory terminations, 9 facility closures, and 12 temporary management appointees. *See* CMS 2006-2014 Enforcement Data.

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[9] *See* Centers for Medicare & Medicaid Services: Center for Clinical Standards & Quality, Survey & Certification Group, Division of Nursing Homes, *Nursing Home Enforcement Reports Through December 31, 2014* (2016), available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-27.pdf, last accessed on September 2, 2022. (Hereinafter "CMS 2006-2014 Enforcement Data.").

C. PENNSYLVANIA DEPARTMENT OF HEALTH ENFORCEMENT.

In furtherance of the dictates of 42 U.S.C. § 1396r, in the Commonwealth of Pennsylvania, nursing homes are regulated and licensed pursuant to Title 28 of the Pennsylvania Code, Chapters 201-211. Sanctions available to the Pennsylvania Department of Health, outlined in Title 28 Pa. Code § 51.41, include four levels of provisional licensure, license revocation, a ban on new admissions, and civil penalties. In the Commonwealth, as contemplated by the FNHRA, the Department of Health conducts annual and complaint-based inspections of nursing facilities to ensure compliance with both Commonwealth and Federal requirements.

From 2014 until 2021, the Department of Health issued 837 penalties for violations of Pennsylvania's long-term care licensing requirements, across all inspections. In those years, 79% of actions taken by the Department of Health consisted of a civil penalty only. The median penalty was $9,394.55 while the penalties averaged $10,837.49, and no civil penalty ever exceeded $100,000.00. No facilities were penalized with a license revocation, and only three were banned from new admissions.[10]

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[10] *See* Pennsylvania Department of Health, *Nursing home sanctions*, available at https://www.health.pa.gov/topics/Documents/Facilities%20and%20Licensing/June%202022%20NCF%20Sanctions.pdf, last accessed on September 2, 2022.

Pennsylvania Department of Health Penalties, 2014-2021			
Total Penalties	Civil Penalties	Median Penalty	Average Penalty
837	663	$9,394.55	$10,837.49

Bans on Admission	License Revoked	Provisional license (all levels)
3	0	171

D. ENFORCEMENT IS NOT COMPREHENSIVE IN PRACTICE.

As this subset of data shows, while the enforcement scheme of the FNHRA purports to give numerous tools for enforcement; in reality, nearly all actions taken by CMS and the Commonwealth of Pennsylvania, involved nothing more than civil penalties. When facilities are sanctioned, they almost always face only a civil penalty (or less). Conversely, temporary denials of payment, mandatory terminations, appointment of temporary management and facility closures are few and far between. Further, regardless of what sanctions are issued, all of them, from the most minor civil penalties to closure of a facility are directed at a facility – none of the sanctions in any way vindicate the individual rights guaranteed residents, let alone compensate residents for deprivations of those same rights.

Beyond the fact that the enforcement mechanisms in the FNHRA are far from comprehensive,[11]federal regulators are not infallible; just because something satisfies federal regulators does not mean it is good enough to protect the public from substantial harm; there is a "laundry list of defective products that also met federal standards yet are known to kill people." Jeff Wigington, *The Best-Selling Defect in America*, 39 Trial 62, 64 (July 2003). One way civil liability complements administrative regulation, as the Supreme Court has pointed out, lies in the ability of civil litigation to shine a spotlight on dangers that regulators may have overlooked or undervalued, prompting agency action "in light of the new information that has been brought to its attention through common law suits." *Bates v. Dow Agrosciences LLC*, 544 U.S. 431, 451 (2005). For example, regarding prescription drugs and medical devices, former Food and Drug Administration Commissioner David Kessler has observed that civil litigation, specifically tort law "often informs regulatory decisions, and the FDA has often acted in response to information that has come to light in state damages litigation." David A. Kessler & David C. Vladeck, *A Critical Examination of the FDA's Efforts to Preempt Failure-to-Warn Claims*, 96 Geo. L.J. 461, 477 (2007-2008); *see also* Aaron S. Kesselheim & Jerry Avorn, *The Role of Litigation in Defining Drug Risks*,

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[11] In addition to the FNHRA itself, there is also regulatory guidance that amplifies the requirements of the FNHRA. *See* 42 C.F.R. part 483, subpart B. These regulations, though amended on occasion, were first published in 1989, shortly after the passage of the FNHRA itself.

297 JAMA 308, 308 (2007) ("[L]awsuits have helped uncover important and previously unavailable data about major adverse events.").

In sum, for more than a decade residents at government-run nursing homes in Pennsylvania have been able to seek legal redress under § 1983 for violations of their rights Congress established in the FNHRA, the same liability upheld by the Seventh Circuit in this case. Pennsylvania's experience has been that this accountability has provided essential legal recourse for elderly victims, has proved workable for the courts, and has not resulted in undue burden to government-run facilities. Additionally, because actual enforcement of FNHRA regulations is directed only at facilities, is less than comprehensive as applied and because the skilled nursing facility regulations cannot cover every possible potential harm, accountability under § 1983 provides an effective complement to administrative regulatory action.

CONCLUSION

For these reasons, this Court should affirm the decision of the Seventh Circuit.

Respectfully submitted,

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