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Commentary on *Linton v. Commissioner of Health and Environment*

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BACKGROUND

The Medicaid Act, a joint federal and state government program, requires states to:

> furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care[.][1]

A core objective of the Medicaid program is to serve the health and wellness needs of elderly, disabled, and low-income individuals. To receive federal funding for Medicaid, states must ensure that these objectives are being met. Health care facilities, such as nursing homes participating in Medicaid, must comply with numerous federal requirements, including providing the state with written assurances of compliance with Title VI of the Civil Rights Act of 1964,[2] which prohibits the exclusion of racial minorities from health care services.[3]

In the 1970s and 1980s, most nursing homes tended to prioritize private-pay, predominately white, patients for admission to increase profits. States allowed nursing homes to limit Medicaid patients by certifying a limited number of their beds for Medicaid, which helped states control their Medicaid costs.[4]

[1] 42 U.S.C. § 1396 (2014).

[2] David Barton Smith, Healthcare Divided: Race and Healing a Nation 100–102, 115–116 (1999).

[3] 42 U.S.C. § 2000d (2000) ("No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance").

[4] Smith, *supra* note 2, at 249, 253–255.

Thus, as the costs for nursing home care continued to grow in the 1990s, nursing homes, with the help of states, tried to limit their admissions to private-pay patients, whose insurance rates could be twice as much as the Medicaid rates.[5] When private-pay patients ran out of money and had to use Medicaid to pay for their stay; then, the nursing home would let them stay in the facility by certifying their bed as a Medicaid bed. As a result, Medicaid, originally a "program designed to care for the poor," was converted "into one that provided a catastrophic long-term care insurance policy for the middle class."[6] These policies also disproportionately harmed racial minorities. According to Professor Barton Smith, as long as nursing homes made a "good faith" effort by marketing with racially nondiscriminatory language and submitting written assurances of nondiscrimination, states certified nursing homes to participate in Medicaid without meaningful investigation of the veracity of these assurances.[7] Although states had authority to regulate nursing homes through licensing and Medicaid certification, they gave nursing homes full discretion in admission decisions to keep costs down.[8] Some nursing homes used this discretion to implement policies that denied or delayed admission to Medicaid patients who were not in a position to provide private payment, especially for racial minority Medicaid patients,[9] in violation of Title VI and the Medicaid Act.[10] This was the case in many states, including in Tennessee.

Tennessee had a fragmented system of long-term care where private nursing homes served rich whites, while public nursing homes served poor whites and unlicensed boarding homes served racial minorities.[11] More specifically, there was "a statewide system of licensed nursing homes, [where] 70 percent funded

5 *Id.* at 254.

6 *Id.*

7 *Id.* at 236; David Barton Smith, *The Racial Integration of Health Facilities*, 18 J. HEALTH POL. POL'Y & L. 851, 857–861 (1993).

8 *See* US COMM'N ON CIVIL RIGHTS, THE HEALTH CARE CHALLENGE: ACKNOWLEDGING INEQUITY, CONFRONTING DISCRIMINATION, AND ENSURING EQUALITY: THE ROLE OF GOVERNMENTAL AND PRIVATE HEALTH CARE PROGRAMS AND INITIATIVES 64 (1999); SMITH, *supra* note 2, at 87.

9 *See* Linton *ex rel.* Arnold v. Comm'r Health & Env't, Tennessee (Linton I), 779 F. Supp. 925, 927 (M.D. Tenn. 1990) (ruling that Tennessee's bed certification policies fostered racial discrimination and delays in admission to nursing homes in violation of Title VI and Medicaid and ordered the state to change its policies).

10 *See* David Falcone & Robert Broyles, *Access to Long-Term Care: Race as a Barrier*, 19 J. HEALTH POL. POL'Y & L. 583, 588–592 (1994); William Weissert & Cynthia Cready, *Determinants of Hospital-to-Nursing Home Placement Delays: A Pilot Study*, 23 HEALTH SERVS. RSCH. 619, 632, 641–642 (1988).

11 *Linton I*, 779 F. Supp. at 932.

by the Medicaid program, serves whites; while [African Americans] are relegated to substandard boarding homes which receive no Medicaid subsidies."[12] This system was due to Tennessee's decision to control Medicaid costs by permitting certified nursing homes' use of a limited-bed policy for admissions. Under this policy, nursing homes gave admission preferences to private-pay patients by reserving beds for their exclusive use and making beds unavailable to Medicaid patients.[13] As a result of this policy, nursing homes had the power, which they used, to determine whom to admit based on profit and sometimes race. Unlike other states, however, Tennessee nursing homes also used this policy to involuntarily transfer any patient who had already been admitted to the facility because: (1) the patient was initially private-pay, but then switched to Medicaid or (2) the patient's level of care dropped, so that they no longer needed skilled care (covered at a higher Medicaid rate than intermediate care). This practice benefited nursing homes by ensuring access to private-pay patients, while harming poor Medicaid patients, especially racial minority Medicaid patients, who lacked access to medically necessary nursing home care.

Linton v. Tennessee[14] was a class action suit brought by plaintiffs who were eligible for Medicaid (or would be eligible in the future) and were seeking nursing home care in Tennessee. The named plaintiff was Mildred Lea Linton, a white Medicaid enrollee with rheumatoid arthritis who resided in a licensed nursing home. When Medicaid officials determined that Ms. Linton no longer needed high-level care and should be moved to an intermediate care bed, the facility informed her that there was a long waiting list for their limited number of Medicaid-certified, intermediate care beds. Although the facility had eighty-seven intermediate care beds, they had taken advantage of Tennessee's limited-bed policy to certify fewer than half of them for Medicaid. Mrs. Belle Carney, an African American woman with Alzheimer's disease, sought placement in a licensed nursing home, but as a Medicaid enrollee, none was available to her. Mrs. Carney was named as a plaintiff-intervenor. The plaintiffs challenged Tennessee's limited-bed policy under federal Medicaid requirements, including standards governing certification of a "distinct part" of a facility as available to Medicaid-eligible residents. They also challenged the policy under Title VI's prohibition on racial discrimination in programs that receive federal financial assistance,

[12] *Id.* at 932.

[13] *Id.*

[14] 779 F. Supp. 925 (M.D. Tenn. 1990), *aff'd* 65 F.3d 508 (6th Cir. 1995), *cert. denied* 116 St. Ct. 1546 (1996).

arguing that the policy resulted in a disparate impact on African American Medicaid enrollees.

ORIGINAL OPINION

District Court Opinion

In the initial *Linton* case, the district court ruled for the plaintiffs, finding that Tennessee's policies giving nursing homes total discretion to certify a limited number of beds for Medicaid-eligible residents delayed access to necessary medical services and thereby violated the federal Medicaid Act's "reasonable promptness" requirement, among other provisions. The court further held that Tennessee's limited-bed policy violated Title VI of the Civil Rights Act of 1964 because it disproportionately impacted African American Medicaid patients' access to nursing homes.[15] As a result of this case, Tennessee submitted a proposed remedial plan to the district court. The portion of the plan aimed at remedying the state's Medicaid Act violations included the following provisions: First, the remedial plan required "full certification."[16] The plan "required Medicaid providers to certify all available, licensed nursing home beds within their facilities . . . and to admit residents on a *first-come, first-serve* basis."[17] Second, the plan "prohibit[ed] involuntary transfer or discharge [of residents] based upon source of payment."[18] Third, a "lock-in" provision required "[p]roviders who chose to withdraw from the system . . . to retain current Medicaid patients and comply with Medicaid requirements as to such patients."[19] Fourth, a "lock-out" provision discouraged nursing homes from withdrawing from Medicaid participation by holding that "[p]roviders who withdrew would be excluded from Medicaid participation for two years after withdrawal."[20] The portion of the remedial plan addressing Title VI violations "included draft rules for Title VI civil rights compliance and enforcement, added staff to Tennessee's Office of Civil Rights Compliance, and incorporated by reference the measures adopted in [the Medicaid compliance portion] of the plan."[21]

[15] *Id.* at 936.
[16] Linton v. Tennessee (Linton II), 65 F.3d 508, 512 (6th Cir. 1995).
[17] *Id.* (emphasis added).
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*

The district court adopted the state's proposed plan without any changes. At that point, five nursing homes licensed in Tennessee filed a motion to intervene for the purposes of appeal, arguing that the district court erroneously found that there were Title VI violations, and thus the remedial plan was invalid. In addition, the Intervenor-Defendants argued that the remedial plan did not conform with the Medicaid Act and that the lock-in and lock-out provisions impaired their contractual relationship with the state, in violation of the US Constitution. The US Court of Appeals for the Sixth Circuit heard this case, which is referred to as *Linton II*.[22]

Circuit Court Opinion

The Sixth Circuit's unanimous decision in *Linton II* rejected the nursing homes' challenge to the remedial plan and upheld the remedial plan in its entirety. Its decision was based only on the requirements of federal Medicaid law and the adequacy of Medicaid reimbursement rates that the state paid to the nursing homes. The court explicitly decided not to address the issues raised by the nursing homes regarding Title VI, on the grounds that "[n]one of the remedies [that the nursing homes challenged on appeal were] predicated on a finding of a Title VI violation, alone." When the Sixth Circuit was deciding *Linton II*, there was ample evidence of the disparate impact discrimination because the policies of the state and the actions of the nursing homes disproportionately harmed racial minority patients and were not justified by a bona fide interest. Thus, they violated the purpose and requirements of Title VI. Nevertheless, the Sixth Circuit's opinion in *Linton II* disregarded this evidence, instead concentrating on the remedial plan's conformance with Medicaid law and "neutral" application of contract law to the nursing homes' argument that the challenged provisions of the remedial plan impaired their contractual relationship with the state.

FEMINIST JUDGMENT

The feminist concurrence by Professor Gwendolyn Roberts Majette, writing as Judge Majette of the US Court of Appeals for the Sixth Circuit, discusses the Title VI claims, finding that Tennessee's limited-bed certification policy had an unjustified disparate impact on racial minorities' access to nursing home care.

[22] *Id.*

Unlike the original opinion, the Majette concurrence adopts an intersectional feminist approach by centering the experience of Mrs. Carney, who intervened in the lawsuit because she was denied access to a Medicaid-certified bed. Ms. Linton, a white Medicaid patient who was the named plaintiff in the suit, was able to obtain a bed in a nursing home, yet the nursing home was threatening to discharge her. However, Mrs. Carney, a disabled, African American, elderly Medicaid patient, was denied a Medicaid-certified nursing home bed for two years and, thus, was relegated to unlicensed boarding homes and emergency room care. Mrs. Carney suffered serious harm due to the state's policy permitting nursing homes to refuse her based on her status as a Medicaid enrollee. Her experience was distinct from Ms. Linton's in ways that are important to the feminist concurrence's reasoning. The concurrence highlights the fact that there was a prima facie case of disparate impact discrimination due to the "abundance of testimony from individuals who sought admission for their family members of color and were turned away."

Majette's concurring opinion makes it clear that it is not enough for nursing homes to certify all beds as available for Medicaid patients, if nursing homes are not also going to be required to provide racial minorities with equal access to those beds. Hence, while the original opinion may have fixed the problems facing Ms. Linton by prohibiting her nursing home from discharging her, it leaves Mrs. Carney and other elderly African American Medicaid patients relegated to unlicensed boarding homes.

The concurrence is further notable because it holds that the plaintiffs established a prima facie case of disparate impact discrimination based on testimony, reports, and statistics, which Tennessee did not rebut. Specifically, the concurrence finds the testimony of Ms. Beverly Bass, the Director of Title VI Compliance for the Tennessee Department of Health and Environment, that, "elderly blacks face challenges to accessing nursing home care statewide," yet they "only comprised 15.4% of the [Tennessee] nursing home population, despite the fact that they comprised 39.4% of the Medicaid population," showed that the limited-bed policy had a disparate impact on African Americans. Additionally, using this statistical evidence and the testimony of many others who were denied admission to nursing homes, the concurrence finds that Tennessee's assertions that the racial differences in nursing home residency are due to self-selection are not legitimate. The concurrence is significant because it holds that the state has violated the requirements of Title VI by allowing nursing homes to deny African American's equal access to nursing home care. Yet, the concurrence does not address how the actions of the nursing homes were also examples of disparate impact discrimination, as discussed below.

DISCUSSION

Majette's concurring opinion in *Linton* expressly relies on feminist legal theory by citing Kimberlé Williams Crenshaw[23] and Martha Albertson Fineman.[24] After highlighting that the case concerns the state's "willingness to protect the health and well-being of all its citizens, especially those that are vulnerable because of the intersection of their age, gender, race, and class," Majette goes on to explain how Crenshaw's theory of intersectionality counsels against "treating a status as mutually exclusive for analytical purposes," and instead calls on the courts to "consider the greater sum of the intersectional experience." Majette notes that the *Linton* decision "raises several societal concerns about aging that are captured by Professor Martha Fineman's theory on the universality of dependency." She adopts Fineman's argument that valuing caretaking requires "that the market and government should bear their fair share of responsibility." She concludes that "Fineman's arguments . . . magnify the importance of the Medicaid program in providing funding to care for the health of poor elderly people which includes the provision of nursing home care." These feminist theories buttress Majette's conclusion that "for the government (federal and state) and the market (nursing home facilities) to assume their fair share of responsibility, they must comply with the dictates of the Medicaid program and Title VI."

Majette's feminist concurrence adds to the original opinion by reaffirming findings of the district court that there was disparate impact discrimination and by explicitly relying on feminist legal theories to do so. However, it does not change the result of the original opinion. Majette's concurrence also does not address the actions of the nursing homes nor does it require the state to undertake additional actions to eradicate the disparate impact discrimination that Mrs. Carney experienced. Additionally, although the feminist concurrence balances out the original opinion's focus on the relationship between the state and the nursing homes by centering the experiences and needs of the plaintiffs, Majette does not directly respond to the original opinion's reliance on contract rights to justify the nursing homes' practices.

Majette misses an opportunity to respond to the original opinion's reliance on freedom of contract by asserting feminist arguments that undermine its

[23] Kimberlé Williams Crenshaw, *Demarginalizing the Intersection of Race and Sex, A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics*, 1989 U. Chi. Legal F. 139 (1989).

[24] Martha Albertson Fineman, The Neutered Mother, The Sexual Family and Other Twentieth Century Tragedies 161–164, 230–236 (1995).

assumptions. As noted by feminist legal scholars, contract law often reinforces the power structures of American society, leaving those without power, such as the poor, susceptible to mistreatment.[25] This was certainly true in the *Linton* opinion.

The freedom of contract defense at issue in the *Linton* cases ignored the history of disparate impact discrimination in nursing homes and was inconsistent with Medicaid requirements. Disparate impact discrimination, often illustrated by data and statistical analysis, is defined as unintentional discrimination that has a disproportionate impact on a protected group, such as racial minorities.[26] The Tennessee policy allowing nursing homes to certify Medicaid beds at their discretion, disproportionately harmed racial minorities because nursing homes would not certify beds for African Americans, and as a result, African American elderly Medicaid patients were often relegated to unlicensed boarding homes.[27] This history of discrimination is important to understanding why the nursing homes' claims about suffering harm from the remedial plan were unpersuasive.

The "first come, first served" and "lock-in" requirements in the remedial plan mandate that Medicaid patients are admitted on a "first come, first served basis" without regard to payment status and are allowed to continue to reside in the facility even if their payment status changes or the nursing home stops participating in the Medicaid program. The nursing homes argued that their choice to certify beds to favor private-pay patients – and retain the option to kick out Medicaid patients residing in the facility – was a "neutral" business justification consistent with their freedom of contract.[28] However, the nursing homes' choices were not neutral with regard to Medicaid status or with regard to race. As discussed in the background section of this commentary and in the district court opinion, nursing homes, with the assistance of Tennessee, maintained a dual system of nursing home care for the rich and the poor as well as for white and African American patients.[29] Nursing homes limited Medicaid patients' access to care to increase profits and often to prevent

[25] *See, e.g.*, Debora Threedy, *Feminists & Contract Doctrine*, 32 IND. L. REV. 1247, 1248–1249 (1999); *see also* Frances E. Olsen, *The Sex of Law*, *in* THE POLITICS OF LAW: A PROGRESSIVE 453 (DAVID KAIRYS ED., 2d ed. 1990); Linda Hirshman, *Foreword: The Waning of the Middle Ages*, 69 CHI.-KENT L. REV. 293 (1993).

[26] *See* Linton *ex rel.* Arnold v. Comm'r Health & Env't, Tennessee (Linton I), 779 F. Supp. 925, 934–936 (M.D. Tenn. 1990).

[27] *Id.* at 932, 934–936.

[28] Linton v. Tennessee (Linton II), 65 F.3d 508, 515–516 (6th Cir. 1995).

[29] *Linton I*, 779 F. Supp. at 932.

admission of racial minorities,[30] in contravention of the purposes of Medicaid and Title VI. Thus, although the original opinion upheld the remedial plan that addressed nursing home admission practices, it ignored the fact that the nursing homes' choices were racially discriminatory, not "neutral."

The nursing homes' business arguments also violated the conditions (akin to contractual requirements) of participating in Medicaid, which the original opinion overlooked in its discussion regarding freedom of contract. In its discussion of the impairment of contract claim, the *Linton II* circuit court opinion emphasized the nursing homes' contractual rights to the detriment of the Medicaid patients' rights to reasonably prompt care. Specifically, the original opinion focused on enforcing the Medicaid contract to ensure that the nursing homes were not suffering substantial harm, while ignoring the fact that nursing homes were causing African American Medicaid patients substantial harm through discriminatory admission policies, which violate the Medicaid conditions of participation.[31] The court probably believed that applying contract law principles to the relationship between the state and the nursing homes in a formally race-neutral way (while setting aside the plaintiffs' disparate impact discrimination claim altogether) would address the problems of Medicaid patients. But, as argued by feminist legal scholar Deborah Threedy, the conception of contract law as "neutral and objective" obscures the extent to which it reinforces bias.[32]

Although "contracts are typically thought of as market transactions" separate from discriminatory intent, the very nature of contracts is to suit people to "act as self-interested, rational, autonomous individuals concerned with the exchange of economic value."[33] Thus, in contracts, those with power often use it to obtain monetary gain from those without power, such as the poor. This unequal bargaining power is why Medicaid was enacted. The government has equal power with the nursing homes. Therefore, the government can negotiate equal access to nursing home care, which the poor alone would not be able to negotiate. The original opinion in *Linton II* disregarded this point when discussing the nursing homes' impairment of contracts claim, instead concentrating on the nursing homes' right to freedom of contract.

Freedom of contract includes two principles. First, "that competent, autonomous individuals are entitled to enter into freely chosen obligations

[30] *Id.*; SMITH, *supra* note 2, at 254; Falcone & Broyles, *supra* note 10, at 588–592; Weissert & Cready, *supra* note 10, at 632, 641–642.

[31] It also violated Title VI. *See Linton I*, 779 F. Supp. at 932–933.

[32] Threedy, *supra* note 25, at 1248.

[33] *Id.* 1250.

with minimal interference from the state."[34] Consent is itself a problematic concept, however. Feminists, borrowing from work on the idea of consent in rape law, argue that "consent" is more nuanced and debatable than many contemporary contract theorists imply.[35] The second principle, "which follows from the first, is that an individual should not have obligations imposed on him (or her) by the state."[36] Thus, contract law includes autonomy and protection, which are both gendered. Men are afforded autonomy, while women are protected.[37] Courts often ignore the inequality of bargaining power between contracting parties,[38] except when one of the parties is a governmental entity. Then courts try to protect the non-governmental party in its freedom of contract.

In the *Linton II* case, the court primarily focused on the nursing homes' claims that the voluntariness of contract, namely freedom of contract, was violated because of a substantial impairment, even though it acknowledged that the freedom of contract standard required it to also discuss whether the state had a "significant and legitimate public purpose behind the regulation, such as remedying of a broad and general social problem."[39] Hence, the court highlights the nursing homes' freedom of contract claims concerning reimbursement when discussing the "first come, first served" and "lock-in" requirements. Yet, the freedom of contract is not absolute;[40] it can be limited by a state's "significant and legitimate public purpose."[41] In this case, Tennessee had a "significant and legitimate public purpose" in increasing access to medically necessary nursing home care for Medicaid patients by imposing the "first come, first served" and "lock-in" requirements.[42] Moreover, the state had a responsibility to ensure that Medicaid patients are provided with care in

[34] Nancy S. Erickson, Muller v. Oregon *Reconsidered: The Origins of a Sex-Based Doctrine of Liberty of Contract*, 30 LAB. HIST. 228, 232 (1989). Thus, contract law includes autonomy and protection, which are gendered. Threedy, *supra* note 25, at 1261. Men are afforded autonomy, while women are protected. *Id.*

[35] Consent is itself a problematic concept. Feminists, borrowing from work on the idea of consent in rape law, argue that "consent" is more nuanced and debatable than many contemporary contract theorists imply. *See* Jean Braucher, *Contract v. Contractarianism: The Regulatory Role of Contract Law*, 47 WASH. & LEE L. REV. 697, 703–706 (1990).

[36] Erikson, *supra* note 34. Thus, contract law includes autonomy and protection, which are gendered. Threedy, *supra* note 25, at 1261. Men are afforded autonomy, while women are protected. *Id.*

[37] Threedy, *supra* note 25, at 1261.

[38] *Id.* at 1263–1264.

[39] Linton v. Tennessee (Linton II), 65 F.3d 508, 517–519 (6th Cir. 1995).

[40] Threedy, *supra* note 25, at 1263–1264.

[41] *Linton II*, 65 F.3d at 517–519.

[42] It also has an interest in addressing racial discrimination as required by Title VI.

a reasonably prompt manner,[43] which is accomplished by requiring nursing homes to admit Medicaid patients on a "first come, first served basis" and prohibiting nursing homes from kicking Medicaid patients out before their health improves.

As a result of nursing homes' unregulated ability to control admissions, Medicaid patients did not receive care in a reasonably prompt manner, a condition of participation in the Medicaid program. When discussing why the nursing homes' "impairment of contract" arguments were not availing, the court mentioned that the "first come, first served" and "lock-in" requirements did not make the Medicaid contract involuntary. Yet, the court failed to acknowledge that these requirements ensured that Medicaid patients received the care that they were guaranteed under the Medicaid Act, which the nursing homes agreed to provide when they voluntarily agreed to enter into a contract to participate in Medicaid. As the district court noted, "just as compliance with Medicaid fire safety standards, quality of care standards and patient protection standards involves some cost or inconvenience, so too does compliance with basic Medicaid requirements,"[44] including admitting Medicaid patients who are poor without discrimination. Hence, nursing homes cannot just decide what conditions of participation in the Medicaid program they want to comply with; they are required to comply with all the conditions of participation. The court should have enforced this expectation in the original opinion by ensuring the remedial plan would prevent discrimination by nursing homes. The court also explicitly declined to address the nondiscrimination requirements of Title VI, which are discussed in Majette's feminist concurrence.

Majette's discussion of Title VI is an important addition, reflecting a feminist commitment to directly confronting subordination. But her feminist rewrite stopped short of requiring additional remedial actions that would have made a difference in the lives of Mrs. Carney and others like her and may have made a difference in the subsequent development of Medicaid law and civil rights law. Both the original opinion and Majette's feminist concurrence fail to discuss the connection between the nursing homes' practices and the harm to elderly African American Medicaid patients, which was poor health outcomes. Denied admission to a nursing home and relegated to unlicensed boarding homes, Mrs. Carney's health declined so much that it required her emergency hospitalization. The failure to also hold nursing homes, who

[43] 42 U.S.C. § 1396a(a)(8) (2020).

[44] Linton *ex rel.* Arnold v. Comm'r Health & Env't, Tennessee (Linton I), 779 F. Supp. 925, 934 (M.D. Tenn. 1990).

intervened in the case as defendants, accountable for their discriminatory practices has allowed them to continue discriminatory practices that have been associated with poor health outcomes for African American Medicaid patients, even as the state of Tennessee implemented the remedial plan.

Due to the remedial plan that the state crafted, the district court adopted, and the Sixth Circuit upheld, Tennessee implemented a regulatory framework that tracked nursing homes' discriminatory admission practices.[45] Specifically, the state required all nursing homes receiving Medicaid payments to submit admission data.[46] The state checked this data against mandated admission lists and the medical records of admitted patients to ensure that the nursing home was not discriminating.[47] Unfortunately, research shows that elderly African American Medicaid patients, like Mrs. Carney, still remained barred from equal access to quality nursing homes.[48]

It is possible that Majette's feminist approach to centering the narrative of Mrs. Carney might have eventually influenced a majority of the circuit court to respond to this data by ordering a more adequate remedy. But the narrative method alone, without a substantive change in the holding, would not have secured justice for Mrs. Carney and similarly situated individuals. If a rewritten feminist majority in *Linton II* had set a new precedent by ruling that nursing homes would no longer be allowed to discriminate against patients because of socioeconomic status and race, these conditions may have changed.

In conclusion, this case demonstrates the distinction between having health care insurance and having access to health care services. Although elderly Medicaid patients have health insurance, they often lack access to nursing home care, which is particularly true for elderly African American Medicaid patients. Furthermore, although conditions on governmental spending are an important lever for reform that required Tennessee to change its regulation of nursing home admission procedures, it is unclear whether it actually resulted in eradicating the dual system of nursing home care based on socioeconomic class and race. The concurring opinion clearly holds Tennessee responsible for this dual system. However, without also holding nursing homes accountable for their actions, the dual system of equal access to quality nursing home care has and will persist.

[45] *Linton I*, 779 F. Supp. at 926.
[46] Tenn. A.D.C. § 1200-13-01-.08 (2009).
[47] *Id.*
[48] SMITH, *supra* note 2, at 254; Falcone & Broyles, *supra* note 10, at 588–592; Weissert & Cready, *supra* note 10, at 632, 641–642.

LINTON V. COMMISSIONER OF HEALTH AND ENVIRONMENT, STATE OF TENNESSEE, 65 F.3D 508 (6TH CIR. 1995)

GWENDOLYN ROBERTS MAJETTE, CIRCUIT JUDGE, CONCURRING

I

I agree with the court's judgment finding a Medicaid violation and concur in the court's conclusion that approval of the remedial plan was not an abuse of the district court's discretion. I write separately to address the issue under Title VI of the Civil Rights Act of 1964, which the majority declined to discuss.

"Historically, policies and actions of the United States government have promoted homesteading, land acquisition, home ownership, retirement, pensions, education, and asset accumulation for some sectors of the population, and not for others. Poor people – blacks in particular have generally been excluded from participation in these state-sponsored opportunities." Melvin Oliver & Thomas Shapiro, *Black Wealth/White Wealth, A New Perspective on Racial Inequality* 4 (1995). Medicaid and Title VI of the Civil Rights Act of 1964 are laws designed to ameliorate structural barriers and promote *economic justice, health justice, and equality.*

Medical practices and health care facilities were segregated prior to the passage of Title VI of the Civil Rights Act of 1964. *Simkins v. Cone* was a leading case that was instrumental in providing a legal and moral basis to prohibit federal funding that supported segregation in health care and to support passage of Title VI of the Civil Rights Act of 1964. 323 F.2d 959 (4th Cir. 1963). Attorney General Robert F. Kennedy filed an amicus brief in support of the plaintiffs, African American physicians and patients, when the case was argued before the US district court. *See* David Barton Smith, *Health Care Divided* 93 (1999). In *Simkins*, the US Court of Appeal for the Fourth Circuit held that racially discriminatory policies that barred African American patients from accessing private hospitals in North Carolina were unconstitutional if the hospitals received federal funds for construction and medical education under the Hill-Burton Act. *Id.* at 970. The court also declared unconstitutional the statutory and regulatory sections of Hill-Burton that allowed waivers to its nondiscrimination provisions by creating a *separate-but-equal exemption. Id.* at 969. The laws and policies violated the Equal Protection Clause of the Fourteenth Amendment and the Due Process

Clause of the Fifth Amendment. The court justified its decision in part to prevent the significant health harms that result from racially discriminatory admissions policies that delay or deny care. Those harms contribute to health disparities such as North Carolina's infant mortality rate for African Americans being twice the rate for white infants and a maternal mortality rate for African American women being five times the rate for white women. *Id.* at 970 n. 23. In an unprecedented act, the Supreme Court signaled its support for ending the use of federal funds to advance racially discriminatory policies by denying the hospitals' petition for writ of certiorari just as Title VI was being debated in the US Congress. Moreover, numerous congressmen cited *Simpkins* as a rationale to pass Title VI. Smith, *supra*, at 101–105.

This case raises issues regarding the willingness of Tennessee to protect the health and well-being of all its citizens, especially those that are vulnerable because of the intersection of their age, gender, race, and class. Instead of treating a status as mutually exclusive for analytical purposes, we consider the greater sum of the intersectional experience. *See* Kimberlé Williams Crenshaw, *Demarginalizing the Intersection of Race and Sex, A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics*, 1989 U. Chi. Legal F. 139 (1989). Two elderly women brought a class action lawsuit against the Tennessee Commissioner of Health, alleging violation of the Medicaid Act and Title VI of the Civil Rights Act of 1964. Ms. Mildred Linton filed her lawsuit in 1987. Ms. Linton was an elderly woman with rheumatoid arthritis who had lived for four years in a nursing home, where she received skilled nursing care services. She was advised that she would be discharged from the facility because it planned to decertify the dually certified Medicaid bed to no longer provide the lower level, intermediate care that she needed. As part of Medicaid distinct part certification, Tennessee allowed skilled nursing facilities, at their discretion, to "spot" certify beds for Medicaid participation. This practice allowed fewer than all beds within a particular wing or floor to be available for Medicaid recipients regardless of their required level of care. In this case, once Ms. Linton moved from needing skilled nursing care to intermediate care, she was told that her bed was no longer certified for Medicaid participation, and she would therefore not have a bed at the facility. In 1989, Mrs. Belle Carney moved to intervene in the lawsuit. Mrs. Carney was an elderly African American woman with Alzheimer's disease who needed skilled nursing care following a hospitalization. No Medicaid bed was found in a nursing home, and she lived in inadequate, unlicensed boarding homes for two years until her health declined, requiring emergency hospitalization.

From 1981 to 1985, prior to implementation of the limited-bed/spot bed certification, Tennessee operated the Bed Management Program. This policy placed a defined percentage limitation on the number of Medicaid beds in a nursing home facility. In 1985, the Health Care Financing Administration (HCFA), the federal agency that administers Medicaid, advised the state to end the policy. Plaintiffs alleged that the limited-bed or spot certification by the Tennessee Department of Health and Environment (TDHE) artificially restricted the number of available Medicaid beds in nursing homes which resulted in discrimination against indigent individuals and minorities. The limited-bed/spot bed certification allowed nursing homes to unilaterally change the designation of a Medicaid bed to a non-Medicaid bed. The lower court agreed with the plaintiffs' arguments and ordered the state to submit a remedial plan to end and prevent present and future Medicaid and Title VI violations. In July 1990, this Court allowed several nursing homes in Tennessee to intervene to appeal the lower court decision.

To prevent patient transfer trauma if nursing homes withdrew from Medicaid instead of fully certifying their beds, the remedial plan included lock-in and lock-out provisions which the Appellant nursing homes challenge on appeal. The lock-in provision allowed existing Medicaid-eligible residents to remain in the facility as long as they wished. However, non-Medicaid residents who subsequently became eligible for Medicaid were only allowed to remain in the facility after the nursing home withdrew from Medicaid until June 30, 1991. After that date, the newly eligible Medicaid residents would be required to move.

On January 24, 1991, the HCFA approved the remedial plan. On June 20, 1991, the remedial plan was slightly revised to replace the June 30, 1991 departure date with a flexible "one-year grace period" from the day the TDHE approved a facility's request to withdraw. The lock-in provision of the remedial plan was revised again on June 30, 1993. This version was more protective of the rights of the existing nursing home beneficiaries because it protected existing Medicaid-eligible residents as well as those that became Medicaid-eligible in the future. The revised lock-in provision allowed for nursing facilities that withdrew from the Medicaid program to continue to receive Medicaid payment for individuals who resided in the facility at the time of the facility's notice to withdrawal. Payment was contingent on "(a) the facility's compliance with all requirements for Medicaid participation; and (b) its agreement to continue to serve, and accept Medicaid payment for, on a non-discriminatory basis, all individuals residing in the facility on the date of notification of withdrawal, who are or become Medicaid-eligible."

Each version of the remedial plan also included a lock-out provision. Nursing homes that left the program were excluded from the program for two years. The state could have waived this exclusion if it served the interest of the remedial plan. If a nursing home violated the remedial agreement, it would have been excluded from participation for five years. The withdrawing nursing homes were also required to notify the existing Medicaid residents, the non-Medicaid residents, and persons on the waiting list of their decision to withdraw from the Medicaid program. While full certification of beds would increase the overall number of beds available to plaintiffs, the more powerful remedy required by Title VI is *equal access* to all the beds that are available. According to the majority opinion, at the time of the lawsuit, 77% of nursing home beds were certified and only 23% were uncertified. *Linton v. Comm'r of Health & Env't*, 65 F.3d 508, 511 (6th Cir. 1995).

II

This Court was tasked with determining if the district court correctly found the remedial plan overbroad, but I write to further determine if the Tennessee limited-bed policy had a disparate impact on blacks (African Americans) in violation of Title VI of the Civil Rights Act of 1964 and its implementing regulations. I find that Title VI alone is sufficient to find the remedial plan illegal.

Seventy percent of Tennessee's Medicaid program is paid for by the federal government. Title VI of the Civil Rights Act of 1964 was designed to remove barriers that limit minority participation in federally funded programs. It was designed to prevent federal money that is raised by taxpayers of all races from being spent in ways that encourage, entrench, subsidize, or result in racial discrimination. *Bryan v. Koch*, 492 F. Supp. 212, 230 (S.D.N.Y. 1980).

Title VI of the Civil Rights Act of 1964 provides: "No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance." 42 U.S.C. § 2000(d). The Supreme Court has held that the Title VI statute prohibits only intentional discrimination. *Guardians Ass'n v. Civ. Serv. Comm'n*, 463 U.S. 582 (1983). However, the implementing regulations go further and specifically prohibit a state from administering its Medicaid program in a manner which:

> directly or through contractual or other arrangements, utilize[s] criteria or methods of administration which have *the effect* of subjecting individuals to

> discrimination because of their race, color or national origin, or have *the effect* of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color or national origin.

45 C.F.R. § 80.3(b)(vii)(2) (emphasis added). To establish a disparate impact case, the plaintiffs must establish a prima facie case that Tennessee's limited-bed certification policy has a disparate impact on racial minorities' access to nursing homes in Tennessee. The burden then shifts to the defendant who must prove that the disparate impact is justified by a legitimate bona fide interest. Plaintiffs may rebut the defendant's justification by showing that other less discriminatory alternatives exist. *Bryan v. Koch*, 627 F.2d 612, 618 (2d Cir. 1980); *NAACP v. Med. Ctr. Inc.*, 657 F.2d 1322, 1336 (3d Cir. 1981).

A

Plaintiffs Linton and Carney established a prima facie case through testimony, reports, and statistics that Tennessee's limited-bed certification policy had a disproportionate effect on African Americans' access to nursing home care. Ms. Beverly Bass, the Director of Title VI Compliance for the TDHE, testified in her deposition that elderly Black people face challenges to accessing nursing home care statewide. App. 001069. She testified that the limited-bed certification policy restricted access to the short supply of nursing home beds and disproportionately affected minorities. Ms. Bass testified that some nursing homes prefer private-pay patients, and the Defendants concede this fact.

Ms. Bass also testified that Black people over sixty-five have a higher reliance on Medicaid. This reliance is caused by a higher rate of poverty among elderly African American Tennesseans, who were twice as likely as elderly whites to live in poverty. The rate of poverty was 41.4% for elderly African Americans compared to 22.4% for elderly whites. 1980 Census data. Another economic disparity that should be considered is wealth. See Melvin Oliver & Thomas Shapiro, *Black Wealth/White Wealth, A New Perspective on Racial Inequality* 5 (1995) (wealth is unevenly distributed and African Americans are disproportionately "cemented to the bottom of society's economic hierarchy"). Additionally, Ms. Bass testified that there was a greater need for nursing home services among elderly minorities because most assessments conclude that they are more likely to have "poor health status" and higher incidences of "handicapping conditions or conditions that impair function." App. 001080. In fact, the life expectancy for African Americans was six years shorter than the life expectancy for whites in 1980. According to

the US Centers for Disease Control and Prevention (CDC), the average life expectancy for whites in 1980 was 74.4 years compared to 68.1 for African Americans. While women live longer than men, the six-year disparity remained, with white women having a life expectancy of 78 years compared to 72.5 for African American women. The disparity in life expectancy increased to seven years in 1990. For whites the life expectancy was 76.1 compared to 69.1 for African Americans. For women the disparity in life expectancy decreased to 5.8 yrs. The life expectancy was 79.4 for whites compared to 73.6 for African Americans. Table 15 (page 1 of 2). *Life Expectancy at birth, at age sixty-five, and at age seventy-five, by sex, race, and Hispanic Origin: United States, selected years 1900–2015*. As a result of the limited-bed certification policy, elderly African Americans in Tennessee only comprised 15.4% of the nursing home population, despite the fact that they comprised 39.4% of the Medicaid population. Statistical evidence of the disparate racial impact of state policies may be used to establish a prima facie case. *Guardians Ass'n*, 463 U.S. at 592–593.

There is a history of discrimination by the nursing homes in Tennessee. In 1980, the Office of Civil Rights for the US Department of Health and Human Services found that the Tennessee Medicaid Agency was not operating its nursing home program in Shelby County (Memphis) in compliance with Title VI. This resulted in the state's adoption of the "first come, first served" admissions rule for Medicaid-funded nursing homes. In 1985, Tennessee was sued because nursing homes discriminated against minority applicants in violation of Title VI, and state officials were complicit in the behavior. Tennessee entered into a consent decree which required them to strengthen their enforcement of the "first come, first served" rule and monitor nursing home compliance with Title VI. *Hickman v. Fowinkle*, No. 80-2014-M (W.D. Tenn. 1985). According to Ms. Bass, the first state survey of Tennessee nursing homes was conducted in 1986. It found that many of the facilities (170 out of 243) continued to be out of compliance with Title VI. App. 001084.

B

Once plaintiffs establish a prima facie case of disparate impact, the burden shifts to the defendant to rebut that evidence. Here, neither Tennessee nor the intervening nursing homes has met that burden. The district court correctly found that Tennessee had not met its burden of proof to rebut the plaintiffs' prima facie case. An assertion that the disparate impact on racial minorities was due to "self-selection preferences of minorities, minorities [*sic*] reliance upon extended family, lack of transportation, and fear of institutional care," is

not a legitimate justification. *Linton v. Comm'r of Health & Env't*, 779 F. Supp. 925, 935 (M.D. Tenn. 1990). This is especially so given that there was an abundance of testimony from individuals who sought admission for their family members of color and were turned away and ombudsmen and community leaders who sought equal access to care in private nursing homes but were denied access because of the nursing homes' preference for private-pay patients.

There is a dual system of nursing home care in Tennessee. The private nursing homes largely serve a disproportionately white patient population in contrast to the large public county-operated nursing homes which disproportionately serve a poorer, minority patient population. Ms. Carney was ultimately admitted to a county-operated nursing home in Davidson County, after the private nursing homes denied her admission. Ms. Bass testified that when you include the publicly run nursing homes in Medicaid statistics, it masks the true extent of barriers that minorities encounter to access admission to private nursing homes.

Accordingly, given that Tennessee has an affirmative duty to monitor facilities to prevent discrimination in Medicaid, it must invalidate provider agreements for certified facilities that "fail to meet the civil rights requirements set forth in 45 C.F.R. Parts 80, 84, and 90." 42 C.F.R. § 442.12(d).

III

For the reasons stated in this concurrence, the district court correctly found that the limited-bed policy had a disparate impact on Black people under Title VI of the Civil Rights Act of 1964. The district court's decision is affirmed.

Mrs. Belle Carney's denied access to appropriate treatment in a private nursing home raises concerns about the intersectionality of race, class, age, and gender. Crenshaw, *supra*. African Americans' reliance on and denial of benefits to the Medicaid program reflect past economic injustices that are structured by law. This class action also raises several societal concerns about aging that are captured by Professor Martha Fineman's theory on the universality of dependency. She notes that aging causes biological and physical dependency on others that should create a shared societal understanding to financially support caregivers. To value caretaking, Professor Fineman argues that the market and government should bear their fair share of responsibility. Martha Albertson Fineman, *The Neutered Mother, The Sexual Family and Other Twentieth Century Tragedies* 161–164, 230–236 (1995).

When Fineman's arguments are applied to the case at hand, they magnify the importance of the Medicaid program in providing funding to care for the

health of poor elderly people which includes the provision of nursing home care. In order for the government (federal and state) and the market (nursing home facilities) to assume their fair share of responsibility, they must comply with the dictates of the Medicaid program and Title VI.

Therefore, I concur in the majority's holding but state my separate reasons for doing so.