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# Implied Causes of Action Under § 1396r: Why *Grammer* Reminds Nursing Home Residents to Actively Participate in Their Own Care

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## I. INTRODUCTION

> They made the mistake of thinking of a personality as some sort of possession, like a suit of clothes, which a person wears. But apart from a personality what is there? Some bones and flesh. A collection of legal statistics, perhaps, but surely no person. The bones and flesh and legal statistics are the garments worn by the personality, not the other way around.[1]

For centuries, society has been searching for the most economic and effective way to care for its elderly.[2] Satisfactory and widespread elder care has remained a constant challenge for society, from the time of poorhouses to today's modern nursing homes.[3] At the center of the situation are a growing number of elderly and an unacceptable quality of care, particularly in nursing homes.[4] The population of adults aged sixty-five and older is expected to almost double by 2030,[5] and even though many of the nation's baby boomers will maintain sufficient health to be independent in the coming years, their sheer numbers will inevitably exacerbate the health care problems present in our nation.[6] That is not to say that an effective and comprehensive health care system for the elderly is infeasible.[7] On the contrary, a successful system of long-term care is quite possible; however, it requires, among other things, the active participation of older persons in their own care.[8] Such "collaborative

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1. ROBERT M. PIRSIG, ZEN AND THE ART OF MOTORCYCLE MAINTENANCE 88 (1974).
2. *See generally* ABE BORTZ, HISTORICAL DEVELOPMENT OF THE SOCIAL SECURITY ACT (n.d.), http://www.ssa.gov/history/bortz.html (last visited Feb. 5, 2010).
3. *See generally* ElderWeb, History of Long Term Care, http://elderweb.com/node/2806 (last visited Feb. 5, 2010). Although the first caretakers of the elderly were their own families, the first attempts by society to care for elders whose families could not support them, whether because of poverty or absence, were institutions such as poorhouses and almshouses. *See id.*
4. *See* INST. OF MED. OF THE NAT'L ACADS., RETOOLING FOR AN AGING AMERICA: REBUILDING THE HEALTH CARE WORKFORCE 11-12 (2008), *available at* http://books.nap.edu/openbook.php?record_id=12089.
5. *See id.* at 1 (The number is expected to grow "from 37 million to over 70 million" by 2030.).
6. *See id.* at 1-2 (explaining that the models of care are outdated and the health care workforce will lack the size and ability to care for the surging elder population).
7. *See id.* at 14 (explaining that the nation can act to avoid the upcoming crisis by changing the way that elder care is administered); *see also* Cynthia Massie Mara, *Focal Points of Change*, *in* HANDBOOK OF LONG-TERM CARE ADMIN. AND POL'Y 415, 422 (Cynthia Massie Mara & Laura Katz Olson eds., 2008) (concluding that change in America's long-term care system requires a streamlining of policies, which should arise from increased dialogue between health care administrators, legislators, and the public).
8. *See* INST. OF MED. OF THE NAT'L ACADS., *supra* note 3, at 12. In addition to active patient participation, the Institute of Medicine envisions that a successful elderly care system will efficiently and comprehensively provide health care through improvements in the way that services are organized, financed, and delivered. *See id.*

care" emphasizes patient self-management through education and treatment planning in contrast to the traditional provider-patient relationship, which tends to emphasize only provider responsibility for a patient's health.[9] While collaborative care may be the preferable model for the earliest stages of elderly care, the more incapacitated a patient becomes by illness and old age, the more difficult it becomes for a patient to self-manage.[10] Nevertheless, a dependent resident may actively participate in her own care by communicating the quality of her care to her family and attorney. Such active patient participation among nursing home residents, whether by the dependent patient herself or another trusted coordinator, is integral to a successful elder care system.[11]

In a recent decision, *Grammer v. John J. Kane Regional Centers – Glen Hazel*,[12] the U.S. Court of Appeals for the Third Circuit added a new tool to the proverbial toolbox of nursing home reform. The court's holding may be utilized to help repair the quality of care for current state nursing home residents and remind residents of both state and private nursing homes that they are a class of beneficiaries with federal rights that warrant protection.[13] In *Grammer*, the Third Circuit held that Congress intended the Federal Nursing Home Reform Amendments ("FNHRA")[14] to confer individually enforceable rights upon residents of county-run, Medicaid-participating nursing homes.[15] Accordingly, the *Grammer* court held that a resident may bring her claim against a county-

9. *See id.* at 243.

10. *See id.* ("Self-management is predicated on the assumption that patients have both the ability to understand basic health care information . . . and the ability to use that knowledge to help manage their own care. . . .").

11. *See* Megan E. McCutcheon & William J. McAuley, *Long-Term Care Services, Care Coordination, and the Continuum of Care*, *in* HANDBOOK OF LONG-TERM CARE ADMIN. AND POL'Y, *supra* note 7, at 173, 182 (identifying care coordination as a "key component of long-term care").

12. Grammer v. John J. Kane Reg'l Ctrs. – Glen Hazel, 570 F.3d 520 (3d Cir. 2009), *cert. denied*, 130 S. Ct. 1524 (2010).

13. *See id.* at 530 ("The plain purpose of these provisions is to protect rights afforded to individuals."). In addition to reminding residents of their membership in the class, *Grammer's* holding also should remind those involved in a dependent patient's health care about her membership in the class, especially family members and attorneys.

14. 42 U.S.C.S. § 1396r (LexisNexis 2010). The FNHRA also included amendments to 42 U.S.C.S. § 1395i-3, which is the nursing facility section of the Medicare statute. Because the *Grammer* court only considered § 1396r in its analysis of the FNHRA, I will use § 1396r and FNHRA interchangeably.

15. *See Grammer*, 570 F.3d at 532; *see also id.* at 525 n.2 (explaining that the absence of an explicit cause of action within § 1396r does not preclude the finding of an equally enforceable implicit cause of action).

run nursing home under 42 U.S.C. § 1983[16] for violating specific provisions of the FNHRA while acting under color of state law.[17]

Only a small percentage of Medicaid-certified nursing homes ("certified nursing homes") are owned and operated by state or county governments ("state-run nursing homes").[18] Most certified nursing homes are owned and operated by for-profit enterprises or private non-profit organizations ("privately-run nursing homes").[19] Thus, the most obvious beneficiaries of *Grammer's* holding, residents of state-run nursing homes whose federally enforceable rights under § 1396r have been violated, are fewer in number than similar residents of privately-run nursing homes. For these latter residents, *Grammer's* holding has a different meaning. Because the Third Circuit defined the class of beneficiaries upon which Congress conferred rights under § 1396r as all Medicaid recipients of Medicaid-participating nursing homes, residents of privately-run nursing homes can cite *Grammer* as strongly persuasive dicta when bringing claims against privately-run facilities.[20] One cause of action likely to be raised by such a plaintiff after *Grammer* is whether, as a resident of a privately-run nursing home, she may sue the facility under § 1983 for acting under color of state law.[21] Without a doubt, both

16. 42 U.S.C. § 1983 (2006).

17. *See Grammer*, 570 F.3d at 532. Although the court did not explicitly state that the defendant county-run nursing home operated under color of state law for the purposes of § 1983, according to the attorney for the plaintiff, the parties stipulated to the defendant being a state actor. *See* Email from Robert F. Daley, Attorney, Robert Peirce & Assocs., to Edward J. Cyran, Associate Editor, The Penn State Law Review (Sept. 17, 2009, 22:26 EDT) (on file with author).

18. *See* CHARLENE HARRINGTON, HELEN CARRILLO & BRANDEE WOLESLAGLE BLANK, NURSING FACILITIES, STAFFING, RESIDENTS AND FACILITY DEFICIENCIES, 2003 THROUGH 2008, at 20 (2009), *available at* http://pascenter.org/documents/OSCAR_complete_2009.pdf. The OSCAR database, fully known as the On-line Survey, Certification and Reporting System, contains the annual data obtained from the state surveys of certified nursing homes. *See id.* at 1.

19. *See id.* I include only Medicaid-certified, privately owned and operated nursing homes under this appellation.

20. Plaintiff-residents of privately-run nursing homes can cite *Grammer* as persuasive precedent in order to show that they are members of the class of beneficiaries upon whom Congress conferred individual rights under § 1396r. Their rights may or may not be enforceable. *See* discussion, *infra* Part III.

21. To establish a § 1983 claim, the plaintiff must show that she was deprived of a right under the Constitution or laws of the United States and that the deprivation was caused by a state actor. *See* Am. Mfrs. Ins. Co. v. Sullivan, 526 U.S. 40, 49-50 (1999); *see also* 42 U.S.C. § 1983. The statute states:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States . . . to the deprivation of any rights, privileges, or immunities secured by the Constitution and its laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. . . .

privately-run nursing homes and their residents are interested in the answer. This Comment will explore the question and conclude that privately-run nursing homes likely do not act under color of state law in the course of their operations, even though they must adhere to § 1396r as Medicaid-certified facilities and they receive substantial state and federal funding.

Without a claim of state action to enforce her newly-recognized federal rights, a plaintiff-resident of a privately-run nursing home may seek to enforce her rights through a private cause of action under § 1396r. This Comment will explore a private cause of action under § 1396r and conclude that, while Congress likely intended to include residents of privately-run nursing homes in the protected class of beneficiaries under the statute, there is not enough evidence to suggest that Congress also intended to provide a private cause of action for these residents.

Part II of this Comment will discuss the history of certified nursing homes, including the rise of nursing home "chains" and the decline of quality of care. This Comment will then analyze whether a § 1983 claim may be brought by a hypothetical *Grammer* plaintiff against a privately-run nursing home and, alternatively, whether such a plaintiff has a private cause of action under § 1396r. Finally, this Comment will conclude that litigation is an important and necessary part of the future of elder care in America; however, adding a new branch to § 1983 jurisprudence by finding a privately-run nursing home to be a state actor is neither warranted nor necessary. Moreover, although a private cause of action likely does not exist under § 1396r for residents of privately-run nursing homes, plaintiffs likely would not employ such a cause of action. Consequently, *Grammer's* legacy in elder care will be significant for other reasons. For example, the *Grammer* case may solidify the potency of certain state law claims.[22] Regardless, the primary contribution of

42 U.S.C. § 1983.

22. Prior to *Grammer*, courts disagreed as to whether violations of § 1396r could be considered negligence per se, but tended to agree on whether such violations could be used as evidence of negligence. *Compare* McLain v. Mariner Health Care, Inc., 631 S.E.2d. 435, 438 (Ga. Ct. App. 2006) (holding that § 1396r appropriately establishes the standard of care for a nursing home, whether under negligence per se or an ordinary negligence action), *and* McCain v. Beverly Health & Rehab. Servs., Inc., No. 02-657, 2002 U.S. Dist. LEXIS 12984, at *4-6 (holding that a plaintiff could maintain a cause of action in negligence per se under the regulations), *with* Frantz v. HCR Manor Care, Inc., 64 Pa. D. & C.4th 457, 469 (C.C.P. Schuylkill 2003) (granting demurrer on all negligence per se claims but one because plaintiff-resident only had an implied right under a certain regulation, yet suggesting that violations may be evidence of negligence), *and* Goda v. White Cliff Leasing P'ship, 62 Pa. D. & C.4th 476, 481-85 (C.C.P. Mercer 2003) (also granting demurrer on all claims of negligence per se except one federal regulation, but silent on whether violations were evidence of negligence).

*Grammer* to elder care will be its role as a cynosure: reminding residents of certified nursing homes that the federal government is concerned with their protection and quality of life, and inspiring dependent nursing home residents and their families to actively participate in elder care. It is truly in this manner that *Grammer* and its progeny will be integral in forming the solution to the rising challenges of long-term care in America.

## II. BACKGROUND

### A. *Medicaid and Nursing Homes*

Title XIX of the Social Security Act, commonly known as the "Medicaid Act," promulgates the cooperative program between federal and state[23] governments known as "Medicaid."[24] Medicaid is designed to furnish medical assistance to low-income individuals aged sixty-five or over, among others, through a combination of federal and state funding.[25] Each state is responsible for administering Medicaid to qualified citizens and complying with the requirements of both the

Because *Grammer* held that § 1396r confers individual rights upon residents of certified nursing homes that are enforceable in the presence of a remedy, future courts will be more inclined to find that § 1396r and its corresponding regulations fulfill the elements of a negligence per se claim. Nevertheless, because the ultimate decision is one of state law, courts may divide along state lines. *See* Burney v. 4373 Houston, LLC, No. 5:05-cv-255, 2005 U.S. Dist. LEXIS 34686, at *6-7 (noting "[e]ven though Plaintiffs refer to a federal regulation as part of their negligence per se claim, it arises purely under state law and does not present a federal question"). In addition to strengthening a plaintiff-resident's claim of negligence per se, a resident's inclusion in the class of beneficiaries under § 1396r may have an impact upon a resident's claims of third-party beneficiary breach of contract, corporate negligence, fraudulent misrepresentation, and deceptive trade practices. Because all of these causes of actions are governed by state law and may or may not include a standard of care, this Comment will not discuss the impact of *Grammer's* holding upon these claims.

23. In addition to fifty state programs, five U.S. Provinces and the District of Columbia administer programs. *See* GAO, MEDICAID PROGRAM INTEGRITY: FEDERAL PROGRAMS TO PREVENT AND DETECT IMPROPER PAYMENTS, NO. GAO-04-707, at 4 (July 2004), *available at* http://www.gao.gov/new.items/d04707.pdf. I will refer to all participating entities as states.

24. *See* 42 C.F.R. § 430.0 (2010); *see also* Grammer v. John J. Kane Reg'l Ctrs. – Glen Hazel, 570 F.3d 520, 523 (3d Cir. 2009) (quoting Sabree *ex rel.* Sabree v. Richman, 367 F.3d 180, 182 (3d Cir. 2004)). The Medicaid Act is codified at 42 U.S.C.S. §§ 1396a-1396w-2 (LexisNexis 2010).

25. *See* 42 C.F.R. § 430.0 (explaining that Federal grants to States under Medicaid are to be distributed for "medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children"). A formula based on each state's per capita income determines the amount of federal contribution to that state's Medicaid program. GAO, MEDICAID PROGRAM INTEGRITY: FEDERAL PROGRAMS TO PREVENT AND DETECT IMPROPER PAYMENTS, *supra* note 23, at 4. The state is responsible for the remaining funds. *Id.* In 2004, federal contribution ranged from 50 to 77 cents per dollar spent on Medicaid. *Id.*

Medicaid Act and its corresponding federal regulations.[26] Medicare is a separate federal program specifically designed to provide health insurance to the elderly and disabled.[27]

In 1987, Congress passed the Omnibus Budget Reconciliation Act of 1987 ("OBRA"), which included the then-new Federal Nursing Home Reform Act.[28] Prior to this amendment of the Medicaid and Medicare Acts, only two sanctions existed against nursing homes that failed to comply with federal participation requirements.[29] First, the Secretary of Health and Human Services ("Secretary") or state agencies could terminate non-complying facilities from Medicaid and Medicare participation, and second, where the noncompliance did not place residents in immediate jeopardy, the Secretary or state agencies could "deny payment for new admissions to the facilities for up to eleven months. . . ."[30] While preparing the FNHRA legislation, Congress found that states rarely imposed these sanctions, which resulted in many "marginal or substandard" nursing homes that were "chronically out of compliance" or frequently falling out of compliance.[31] Distressed with the quality of care in the nation's nursing homes, Congress enacted the FNHRA to provide legislation that would ensure a high quality of care among those nursing homes participating in the Medicaid and Medicare programs.[32] Some of the most notable provisions of the FNHRA include replacing "conditions" and "standards" of participation for nursing facilities with "requirements"[33] and requiring nursing facilities to care for

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26. *See* 42 C.F.R. § 430.0. For specific state responsibilities, see 42 U.S.C.S. § 1396a.

27. *See* 42 U.S.C.S. § 1395c. The Medicare Act is codified at 42 U.S.C.S. §§ 1395-1395iii. Its corresponding federal regulations are located at 42 C.F.R. § 405. Medicare and Medicaid have similar nursing home statutes and regulations. *Compare* 42 U.S.C.S. § 1395i-3, *and* 42 C.F.R. § 405 (laying out Medicare's nursing home provisions), *with* § 1396r, *and* 42 C.F.R. § 430 (laying out Medicaid's nursing home provisions).

28. Although the Act was first abbreviated as FNHRA, this acronym now refers to the Act in its later appellation, the Federal Nursing Home Reform Amendments. *See Grammer*, 570 F.3d at 523 n.1.

29. *See* H.R. REP. NO. 100-391(I), at 466, 470-72 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-201, 2313-286, 2313-290 to 2313-291 [hereinafter HOUSE REPORT].

30. *Id.* at 470-72. *See also Grammer*, 570 F.3d at 523.

31. *See* HOUSE REPORT, *supra* note 29, at 470-72.

32. *See id.* at 452 ("[Congress] is deeply troubled that the Federal government, through the Medicaid program, continues to pay nursing facilities for providing poor quality care to vulnerable elderly and disabled beneficiaries."). The report also states:

> In the view of the [Budget] Committee, all residents of nursing facilities should receive high quality care, regardless of their source payment. Nursing care and related medical services, in particular, must be at the highest level, whether a resident is paying for his or her care, or is being assisted by family members, or is entitled to Medicare or Medicaid benefits.

*Id.* at 458.

33. *Id.* at 453-54.

their residents in a "manner and environment" that promotes the residents' "quality of life."[34]

An integral aspect of the FNHRA is its enforcement scheme, designed to be managed by the Centers for Medicare and Medicaid Services ("CMS") and administered by state agencies.[35] Congress outlined new powers for the Secretary and CMS.[36] The most notable is that, regardless of whether or not a violation "immediately jeopardizes the health or safety of residents," the Secretary or state agency may terminate the facility from the program.[37] In practice, however, it seems that termination is not frequently imposed. According to the GAO, out of 4,830 immediate sanctions for frequent and recurring harm to residents between 2000-2002, 26 resulted in termination, and only one resulted in a transfer of residents and closure of the facility.[38] Alternatively, the Secretary or state agencies may opt for other less deterring penalties.[39]

In addition to enforcement regulations, the FNHRA outline survey regulations and certification regulations. The Amendments require that participating nursing homes pass a standard survey given once every fifteen months on an undisclosed date by the state agency.[40] A grade of "substandard care" results in an extended follow-up survey within two weeks, and the survey must be given without prior notice.[41] For a nursing home to earn Medicaid or Medicare certification, attainment of which is necessary to treat Medicaid or Medicare patients, the nursing home must be licensed by state and local law and meet other federal requirements.[42] The state agency charged with administration of the

34. *Id.* (also stating that nursing facilities are required to have a plan of care for each resident that provides "services and activities" designed to "attain or maintain the [resident's] highest possible physical and mental health, and psychosocial well-being").

35. *See* Marie-Therese Connolly, *Federal Law Enforcement in Long Term Care*, 4 J. HEALTH CARE L. & POL'Y 230, 239-43 (2002) (noting that "[CMS] administers the Medicare program, oversees the states' implementation of the Medicaid program, and is charged with ensuring that providers meet federal care standards").

36. *See* 42 U.S.C.S. § 1396r(h)(1)-(9) (LexisNexis 2010).

37. 42 U.S.C.S. § 1396r(h)(1)(A)-(B).

38. *See* GAO, NURSING HOME QUALITY: PREVALENCE OF SERIOUS PROBLEMS, WHILE DECLINING, REINFORCES IMPORTANCE OF ENHANCED OVERSIGHT, NO. GAO-03-561, at 83 (July 2003), *available at* http://www.gao.gov/new.items/d03561.pdf. A possible reason for such low numbers is the "difficulty and undesirability of relocating residents" when decertification financially forces facility closure. HOUSE REPORT, *supra* note 29, at 471.

39. Less intimidating sanctions include denial of payment for treatment of a specific resident, fines for each day a facility is not in compliance, or appointment of temporary management to oversee the return of the facility to compliance. *See* 42 U.S.C.S. § 1396r(h)(2)(A); 42 C.F.R. § 488.400 (2010).

40. *See* 42 U.S.C.S. § 1396r(g)(2).

41. *See id.*

42. *See* 42 C.F.R. §§ 483.1, 483.75.

Medicaid and Medicare programs is responsible for inspecting the facilities for state licensing.[43] Upon certification, a nursing facility may begin receiving reimbursement for treating Medicaid and Medicare patients.[44]

Currently, there are approximately 16,500 certified nursing facilities, of which state agencies surveyed 15,531 in 2008.[45] These facilities served more than 1,388,383 residents and had an average occupancy rate of 84.22%.[46] One of the most significant trends among certified facilities over the last twenty years has been the increase of ownership "chains."[47] Since the 1990s, for-profit nursing home chains have been notorious for their low quality of care and inadequate staffing levels.[48] Because of their prevalence among nursing homes, understanding the history and rise of chains is critical to understanding the current state of care in nursing homes around the country. The next section of this Comment will examine for-profit nursing home chains.

### *B. For-Profit Nursing Homes and the Rise of Nursing Home "Chains"*

Beginning in the 1950s, for-profit nursing homes became attractive investments for entrepreneurs.[49] During that decade, Congress created a government-supported market that included a vendor payment system, which reimbursed states for direct payments to nursing homes and increased accessibility to government-backed loans for nursing home construction.[50] At the time, the legislation was Congress' method of increasing the supply of nursing home beds and shifting residents from poorhouses and charitable homes to new facilities.[51] After the passage of

43. For Medicaid, see 42 U.S.C.S. § 1396g. For Medicare, see 42 U.S.C.S. § 1395i-3(g)(1)(a).

44. *See* Brogdon *ex rel.* Cline v. Nat'l Healthcare Corp., 103 F. Supp. 2d 1322, 1327 (N.D. Ga. 2000).

45. *See* HARRINGTON, CARRILLO & WOLESLAGLE BLANK, *supra* note 18, at 8. All 16,500 facilities are not surveyed in a calendar year. *Id.*

46. *See id.* at 14. Since not all 16,500 certified facilities were surveyed, the population of residents is understated. *See id.* at 8.

47. *See* Charlene Harrington, *Long-Term Care Policy Issues*, *in* POL'Y AND POL. IN NURSING AND HEALTH CARE (6th ed., forthcoming 2010).

48. *See Trends in Nursing Home Ownership and Quality: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 110th Cong. (2008) (statement of Charlene Harrington, Ph.D., Professor, Sociology and Nursing, Department of Social and Behavioral Sciences, University of California).

49. *See* Catherine Hawes & Charles D. Phillips, *The Changing Structure of the Nursing Home Industry and the Impact of Ownership on Quality, Cost, and Access*, *in* FOR-PROFIT ENTERPRISE IN HEALTH CARE 492, 495-96 (Bradford H. Gray ed., 1986).

50. *See id*. Before the Medicaid Act was passed in 1965, the vendor payment system was part of another need-based federal grant system called "old age assistance." *Id.* at 494.

51. *See id.* at 494-96.

the Medicare and Medicaid Acts in 1965, there became an even higher need for nursing home beds, and Congress responded by increasing reimbursement rates to include not only reported costs, but a proprietary profit.[52] Additionally, Congress provided a lax standard of compliance by requiring facilities only to substantially comply with Medicare health and safety regulations in order to obtain certification.[53] The natural response to these measures was an influx of new providers, increasing the number of nursing home beds nationally from 460,000 in 1965 to more than 1.1 million by 1973.[54] Because nursing home owners received full political, financial, and regulatory support, it was only a matter of time before Wall Street became infatuated with the prospects of the industry.[55] Soon, stock prices of the first nursing home "chains"[56] rose substantially.[57]

Although the boom was short-lived,[58] the nursing home chains had only begun their reign. Overcoming changes in reimbursement and regulatory policies, nursing home chains continued to prosper by relying on the increasing demand for long-term care, reduced expenditures, and the economic benefits of chain ownership.[59]

Chain ownership increased substantially in the 1990s behind the idea that chain-owned nursing facilities were a more efficient way to manage nursing home care.[60] Specifically, the process of "chaining" nursing homes together was touted by management researchers as an effective way to improve quality of care.[61] In 1991, 39% of nursing homes were owned and operated by corporate chains.[62] By 2003,

52. *See id.* at 498.
53. *See id.*
54. *See id.*
55. *See id.* at 499.
56. A nursing home "chain" is generally defined as a "multi-facility organization" consisting of two or more facilities. *See* HARRINGTON, CARRILLO & WOLESLAGLE BLANK, *supra* note 18, at 22; Martin Kitchener et al., *Shareholder Value and the Performance of a Large Nursing Home Chain*, 43 HEALTH SERVS. RES. 1062, 1062 (2008).
57. *See* Hawes & Phillips, *supra* note 49, at 499.
58. *See id.* at 500. Contrary to expectations, the Medicare-supported extended-care market failed to materialize, leaving companies seeking payment through Medicaid for the costs of long-term care patients. *See id.* Unlike Medicare, Medicaid was much more limited in its eligibility and reimbursement rates. *See id.*
59. *See generally id.* at 501-10.
60. *See* Charlene Harrington, *Long-Term Care Policy Issues*, *in* POL'Y AND POL. IN NURSING AND HEALTH CARE, *supra* note 47.
61. *See* Martin Kitchener et al., *supra* note 56, at 1062 (explaining that quality was expected to improve through standardization of services and the centralization of knowledge among member facilities).
62. *See* Banazsak-Holl et. al, *The Rise of Human Service Chains: Antecedents to Acquisitions and Their Effects on the Quality of Care in U.S. Nursing Homes*, 23 MANAGERIAL AND DECISION ECON. 261, 266 (2002).

approximately 52.6% of nursing homes were affiliated with corporate chains.[63] Primarily, this growth was not a result of new facility construction.[64] Rather, this "chaining," or assembly of facilities under one corporation, arose from approximately 5,000 mergers and acquisitions by the largest corporate chains between 1991 and 1997.[65] Although most chains involve no more than ten nursing homes, the eight largest chains operated 2,378 facilities containing almost 20% of all nursing home beds in 2001.[66] In that same year, these eight companies received anywhere from 61% to 82% of their revenue from federal and state funds, and reported total operating revenue ranging between $1.3 billion and $3.1 billion.[67]

While it would be encouraging to report that large chains have delivered on the promise of better quality of care through chain ownership, the eight largest companies have not come close to meeting that goal. First, significant criticism has been levied upon nursing home chains for persistent quality problems and low staffing rates.[68] Researchers have pointed out that issues with quality and staffing are not surprising because the economic advantages of acquiring nursing homes encourage the practice of chaining while inherently decreasing the quality of care.[69] Second, some of these eight chains have run afoul of the law. In 2001, one chain settled a $1.3 billion Medicaid and Medicare fraud claim with the federal government.[70] That same year, the government imposed an independent monitor, as well as criminal and civil penalties, upon another chain for similar reasons.[71] Third, the integrity of these companies has been called into question. In 2000, five of the largest chains in the nation filed bankruptcy out of "necessity," citing the 1997 creation of the Medicare Prospective Payment System as the culprit.[72] Critics, including the U.S. Government Accountability Office ("GAO"), have responded that poor and questionable business

63. *See* HARRINGTON, CARRILLO & WOLESLAGLE BLANK, *supra* note 18, at 22.

64. *See* Martin Kitchener et al., *supra* note 56, at 1065.

65. *See id; see also* Banazsak-Holl et. al, *supra* note 62, at 265 (explaining that the data used for the study were the 1991-1997 OSCAR figures).

66. *See* Martin Kitchener et al., *supra* note 56, at 1065.

67. *See id.*

68. *See id.* at 1066.

69. *See* Banazsak-Holl et al., *supra* note 62, at 262 (explaining that chains may be more willing than independent homes to cut costs and inadequately reinvest profits into facilities, staff, and innovation).

70. *See* Martin Kitchener & Charlene Harrington, *The U.S. Long-Term Care Field: A Dialectic Analysis of Institution Dynamics*, 45 J. OF HEALTH AND SOC. BEHAVIOR (EXTRA ISSUE) 87, 95 (2004).

71. *See* Martin Kitchener et al., *supra* note 56, at 1066.

72. *See id.*

decisions were the true reason for the chains' financial problems.[73] Nevertheless, there is evidence to suggest that chain ownership of nursing homes can be beneficial to quality of care in some respects. For example, acquisitions of poor-quality homes by large chains may significantly improve quality of care after the transaction.[74]

Perhaps the most substantial danger to the quality of nursing home care created by corporate chains is the focus on shareholder value.[75] This classic corporate objective can result in three particularly perilous managerial practices for nursing home residents.[76] First, chains can acquire and merge too rapidly, citing the glory of efficiency and the potential to improve quality among member facilities.[77] Such mergers and acquisitions often involve debt-financing.[78] Second, in the name of cost minimization, chains can constrain expenditures on labor by maintaining nurse staffing levels below state minimums, even in the face of high turnover rates and state government sanctions for poor quality of care.[79] Third, and perhaps most deleterious to quality of care, a chain can treat regulatory sanctions as a normal cost of business, regardless of whether those sanctions are imposed for jeopardizing the health and safety of residents or for unscrupulous corporate governance.[80] To protect shareholder value, chains have taken steps to reduce liability either implicitly or explicitly by placing emphasis on post-acute care,[81] exiting states with high rates of litigation, and establishing limited

73. *See id.* (reporting questionable managerial practices including rapid expansion, large transactions with third parties, bankruptcy filings when facilities should have been closed, and acquisitions of new facilities to convert Medicaid beds into higher-income generating Medicare beds or to establish Real Estate Investment Trusts for lease to other corporations).

74. *See* Banazsak-Holl et al., *supra* note 62, at 276 (explaining, however, that "[h]ealth performance will suffer if the acquiring chain has a history of problems or if the target home has previously achieved a high-quality level.").

75. *See* Martin Kitchener et al., *supra* note 56, at 1078.

76. *See id.* Although Martin Kitchener et al.'s case study completely focused on one large corporate chain, Sun Healthcare, Inc., over a twelve year period from 1993-2005, evidence of similar strategies among other large chains suggest that incentives are not materially different among large chains. *See id.* at 1063, 1080.

77. *See id.*

78. *See*, *e.g.*, *id.* (explaining that although Sun's stock price increased from speculation, Sun was engulfed in massive debt, encumbering the company amidst poor quality performance).

79. *See id.* at 1078-79.

80. *See id.* at 1079 (also explaining that although many of the sanctions came before Sun declared bankruptcy in 2000, "strong traces" of this policy persisted after restoration of the company).

81. Shifting the focus of patient care from chronic care to post-acute care (rehabilitative care relating to an acute condition, such as hip surgery) secures more payments from Medicare, which historically pays higher reimbursement rates and supports transient patients. *See* Hawes & Phillips, *supra* note 49, at 500, 504-05.

liability companies.[82] Ultimately, the incentives of for-profit nursing home ownership, quintessentially represented in large corporate chains, lead to lower costs, greater accessibility, and higher efficiency than nonprofit nursing home ownership, but also to lower quality of care.[83] With nonprofit nursing home ownership, the converse is true.[84] Notably, nonprofit nursing homes seem to deliver care in a more honest manner than for-profit nursing facilities[85] and often serve as a testing ground for new services and treatments otherwise unavailable to for-profit nursing home residents.[86] Furthermore, the seemingly beneficial market elasticity of for-profit nursing homes tends to disturb the delivery of care by incentivizing for-profit facilities to manipulate resident care when benefit plans are disrupted.[87] While it is likely best to have a combination of both for-profit enterprise and nonprofit endeavors, it is quite unclear what proportion of for-profit ownership is preferable.[88] What *is* clear are the perils of for-profit ownership to the quality of nursing home care.

### *C. The Need for Nursing Home Reform*

Although part of the nursing home saga, a history of for-profit enterprise and its incentives does not fully elucidate the state of the industry. In 2008 alone, over 90% of nursing homes around the country received 150,000 deficiencies.[89] These deficiencies were given for failing to meet federal quality standards for pressure ulcers, accidents, infections, and unnecessary patient weight loss, among others.[90] Additionally, out of 65,000 complaints of poor quality of care to state

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82. *See* Martin Kitchener et al., *supra* note 56, at 1079-80.

83. *See* MARK SCHLESINGER & BRADFORD H. GRAY, WHY NONPROFITS MATTER IN AMERICAN MEDICINE: A POLICY BRIEF 9-10 (Aspen Inst. 2005), *available at* http://www.aspeninstitute.org/sites/default/files/content/docs/pubs/Healthcare%20Brief.pdf.

84. *See id.* at 10-11.

85. *See id.* at 10 (explaining that because nonprofit health care providers are "less likely to make misleading claims, less likely to have complaints lodged against them by their patients, and less likely to treat less-empowered patients in a manner different from other clientele," they appear to deliver more "trustworthy" health care than for-profit nursing homes).

86. *See id*. (explaining that nonprofit nursing homes are able to offer services that would be otherwise restrained by the standardization of payment systems in for-profit nursing homes).

87. *See id.* at 11.

88. *See id.* at 15-17.

89. Deficiencies are citations given to facilities for failing to meet a predetermined standard of resident health or safety. *See* CHARLENE HARRINGTON, HELEN CARRILLO & BRANDEE WOLESLAGLE BLANK, *supra* note 18, at 76.

90. *See id.* at 76-86.

regulatory authorities in 2008, 26% constituted serious deficiencies.[91] As if these statistics were not alarming enough, the GAO reported that between 2002 and 2007 approximately 70% of federal comparative surveys performed by CMS identified state regulatory surveys that missed at least one deficiency with "the potential for more than minimal harm."[92] Furthermore, in forty-five different states, CMS discovered that state surveyors missed over 40% of these lower-level deficiencies in certified nursing homes.[93] Additionally, nine states missed over 25% or more of the serious deficiencies in nursing homes within their borders and only seven states missed no serious deficiencies.[94]

The disgraceful conditions that these statistics elucidate confirm the continuing struggle, on both the state and federal government levels, to monitor the quality of care in nursing homes.[95]

## III. WHAT CAUSE OF ACTION DO RESIDENTS OF PRIVATELY-RUN NURSING HOMES HAVE AGAINST THEIR FACILITIES UNDER § 1983 OR § 1396R?

### A. *The Grammer Case and the Hypothetical Plaintiff*

For the purposes of this Comment, the hypothetical plaintiff is quite similar to the plaintiff in the *Grammer* case. The hypothetical plaintiff is the estate of a decedent who claims that a privately-run nursing home violated the decedent's § 1396r rights by actions that, in turn, caused her death. The tort claims brought by the estate are wrongful death and survival. The plaintiff's attorney would like to know whether the plaintiff has a remedy under § 1983 for the violation of the plaintiff's § 1396r rights, or in the alternative, whether the plaintiff has a remedy under § 1396r itself. This section of the Comment will seek to answer

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91. *See id.* at 76. Serious deficiencies are defined as those that cause actual harm or place nursing home residents in immediate jeopardy. *See id.*

92. GAO, NURSING HOMES: FEDERAL MONITORING SURVEYS DEMONSTRATE CONTINUED UNDERSTATEMENT OF SERIOUS CARE PROBLEMS AND CMS OVERSIGHT WEAKNESSES, NO. GAO-08-517, at 4 (May 2008), *available at* http://www.gao.gov/new.items/d08517.pdf.

93. *See id.* The GAO further opines, "[Deficiencies that cause at least minimal harm] are of concern because they could become more serious over time if nursing homes are not required to take corrective actions." *Id.*

94. *See* GAO, *supra* note 92, at 4. The GAO also expressed concern that the number of all deficiencies may be significantly understated due to poor aptitude among state surveyors and weaknesses in the federal monitoring program itself. *See id.* at 4-5.

95. Over the last decade, the GAO, under both its current name and prior appellation as the U.S. General Accounting Office, has investigated and documented the serious state of the quality of care issues among Medicaid-certified nursing homes. To access these reports, see the GAO website at http://www.gao.gov.

whether the hypothetical plaintiff will succeed in bringing these claims against a privately-run nursing home.

It is the task of the Judiciary to determine whether Congress intended to create a private cause of action under a federal statute.[96] Federal statutes may explicitly or implicitly authorize private causes of action.[97] To find a private cause of action, the court must first determine whether Congress intended to confer individual rights upon a class of beneficiaries.[98] If the court finds affirmatively, then the court must determine whether Congress intended to create a corresponding remedy to enforce that right.[99] In cases where the plaintiff claims that one of her federal rights has been violated by a state actor, that right is presumptively enforceable under § 1983.[100] In other words, § 1983 serves as the remedy in those cases, without inquiry into Congress's intent to create a remedy within the statute in question.[101] After the presumption has been raised, the burden shifts to the defendant in the matter, the state actor, to prove that Congress foreclosed private enforcement of the right or rights either expressly, through intrinsic evidence, or impliedly, through a comprehensive remedial scheme that is "incompatible" with private enforcement under § 1983.[102] If the plaintiff is not suing a state actor, § 1983 is not available as a remedy, and the court must determine whether Congress intended to confer a private remedy under the statute.[103]

Prior to *Grammer*, a resident of a state-run nursing home who wished to bring a tort claim against the facility for violating a provision of § 1396r would be facing an uphill battle, not only because she lacked a federally enforceable right, but also because state-run nursing homes could claim immunity from state tort actions under their respective states' laws.[104] Now, after *Grammer*,[105] residents[106] of state-run nursing

96. *See* Alexander v. Sandoval, 532 U.S. 275, 286 (2001) (citing Transamerica Mortgage Advisors, Inc. v. Lewis, 444 U.S. 11, 15 (1979)).

97. *See* Grammer v. John J. Kane Reg'l Ctrs. – Glen Hazel, 570 F.3d 520, 525 n.2 (3d Cir. 2009).

98. *See* Gonzaga Univ. v. Doe, 536 U.S. 273, 285 (2002).

99. *See Alexander*, 532 U.S. at 286-87 (explaining that "[w]ithout [a private remedy], a cause of action does not exist").

100. *See Gonzaga*, 536 U.S. at 284.

101. *See id.*

102. *See id.* at 285 n.4 (citing Blessing v. Freestone, 520 U.S. 329, 341 (1997); Wright v. Roanoke Redevelopment and Hous. Auth., 479 U.S. 418, 423 (1987)).

103. *See* Sabree *ex rel.* Sabree, 367 F.3d 180, 188 n.17 (3d Cir. 2004) ("The distinction between implied private rights of action and § 1983 private rights of action rests not in the articulation of rights, but in the availability of a remedy."); *see also* Cannon v. Univ. of Chicago, 441 U.S. 677, 698 n.21 (explaining that § 1983 is "certainly not available" in a case involving a private defendant).

104. Although claims of governmental immunity by state-run and county-run nursing home defendants are not always successful, they can be fatal to a plaintiff's claim and

homes may avoid the assertion of governmental immunity defenses against their tort claims and may enforce their own federal rights under § 1396r by utilizing § 1983 as a remedy.[107] As discussed above, § 1983 is only available as a remedy when suing a state actor for a violation of a congressionally conferred right.[108]

In this hypothetical case, the plaintiff is alleging violations of the same § 1396r rights that the Third Circuit held were unambiguously conferred upon the *Grammer* plaintiff. Because the only distinction between the two plaintiffs is the ownership of their nursing homes, and the hypothetical plaintiff fits the § 1396r class description,[109] there is every reason to suggest that a court would find that the hypothetical plaintiff is a member of the class of beneficiaries upon which Congress conferred individual rights under § 1396r. The sole opposing argument would be that *Grammer* is not mandatory precedent because the hypothetical defendant is not a state-run facility, which would arguably foreclose § 1983 as a viable remedy and free the court from being handcuffed to the *Grammer* holding. Indeed, the *Grammer* court's

involve further litigation. *See* Cramer v. Auglaize Acres, 865 N.E.2d 9, 17-18 (Ohio 2007) (holding that Ohio's Political Subdivision Tort Liability Act abrogates governmental immunity for county-run nursing homes, but recognizing a material question of fact as to whether immunity still applied by an exception); *see also* Howlett *ex rel.* Howlett v. Rose, 496 U.S. 356, 375-76 (1990) (holding that governmental entities subject to § 1983 cannot apply their sovereign immunity laws to avoid liability, but may do so in cases not involving § 1983 remedies).

105. While the Third Circuit in *Grammer* was not the first court to hold that a state-run nursing home resident has an implied right of action under § 1396r and § 1983 against that nursing home, it was the first court to hold that residents of Medicaid-certified nursing homes who are not mentally-ill or mentally-retarded are among the intended class of beneficiaries of the statute. For the first court to find a private cause of action under § 1396r and § 1983, *see Rolland v. Romney*, 318 F.3d 42 (1st Cir. 2003).

106. Neither the *Grammer* court nor the legislative history of the FNHRA clearly establishes whether the protected class under § 1396r includes all residents of certified nursing homes or simply Medicaid recipients. *Compare* Grammer v. John J. Kane Reg'l Ctrs., 570 F.3d 520, 527 (3d Cir. 2009) ("The provisions are obviously intended to benefit Medicaid beneficiaries and nursing home residents. . . ."), *with id.* at 530 ("The various provisions of the FNHRA at issue here place an unmistakable focus on the benefitted class—Medicaid recipients who are residents of Medicaid participating nursing homes." (internal quotation marks omitted)), *and* HOUSE REPORT, *supra* note 29, at 452 ("The central purpose of these amendments is to improve the quality of care for Medicaid-eligible nursing home residents, and either to bring substandard facilities into compliance with Medicaid quality of care requirements or to exclude them from the program."). However, it is clear that the intended class of beneficiaries consists of at least Medicaid recipients of Medicaid-participating nursing homes.

107. A plaintiff suing a state actor need not prove that Congress intended to confer a remedy under the statute in addition to conferring a right. *See Grammer*, 570 F.3d at 525 n.2 (explaining that "§ 1983 itself provides the remedy"); *see also* Gonzaga Univ. v. Doe, 536 U.S. 273, 284-85 (2002) (explaining same).

108. *See supra* notes 101, 103 and accompanying text.

109. *See supra* note 106.

holding can only stand as mandatory precedent within the strictures of its facts: wrongful death and survival claims brought against a county-run nursing home under the theory that the nursing home violated the plaintiff-decedent's § 1396r rights enforceable under § 1983.[110] Nonetheless, the *Grammer* court held that the provisions of the FNHRA conferred individual rights upon plaintiffs exactly like the hypothetical plaintiff—residents of Medicaid-participating nursing homes who are also Medicaid recipients.[111] Almost certainly, the part of *Grammer's* holding regarding the qualities of the rights-bearing class would be strongly persuasive to a deciding court, because the language in the opinion does not rely on the nature of the defendant to determine class membership.[112]

Assuming the court finds that the hypothetical plaintiff is a member of the beneficial class, the next step in the legal analysis depends on the plaintiff's claim. It is most advantageous for the hypothetical plaintiff to argue first that the privately-run nursing home is a state actor under § 1983 because further analysis of a private remedy is unnecessary once § 1983 is invoked by the plaintiff.[113] If unsuccessful in arguing that the privately-run nursing home is a state actor, the plaintiff can fall back upon the statute itself, i.e., whether Congress intended § 1396r to confer a private remedy upon the hypothetical plaintiff. The former issue will be examined in Part B below. The latter issue will be explored in Part C below.

### *B. The Viability of Utilizing § 1983 as a Remedy to Find an Implied Cause of Action against Privately-Run Nursing Homes*

Since the *Grammer* court held that § 1983 may be used as a remedy to a plaintiff's private cause of action against a state-run nursing home,[114] the court did not need to analyze whether the nursing home was a state actor.[115] Thus, the *Grammer* case is neither mandatory precedent nor useful precedent in determining whether a privately-run nursing home is a state actor when treating a Medicaid resident. The issue of state action is appropriately analyzed under its own doctrine.

110. *See Grammer*, 570 F.3d at 523-25.
111. *See id.* at 530.
112. *See supra* note 106.
113. *See* Gonzaga Univ. v. Doe, 536 U.S. 273, 284 (2002) (explaining that "[p]laintiffs suing under § 1983 do not have the burden of showing an intent to create a private remedy because § 1983 generally supplies a remedy for the vindication of rights secured by federal statutes").
114. *See supra* text accompanying note 107.
115. *See supra* note 17 and accompanying text.

The Supreme Court has recognized that a claim upon which relief may be granted under § 1983 requires two main elements.[116] First, the plaintiff must show that she has been deprived of a right protected by the Constitution or Federal law.[117] Second, the plaintiff must prove that the defendant deprived the plaintiff of that right by acting under color of state law.[118] As discussed in Part A above, the hypothetical plaintiff likely can show a violation of a federal right, thereby fulfilling the first element of the claim. The second element requires action "under color" of state law, which the Court has recognized as akin to "state action" under Fourteenth Amendment jurisprudence.[119] Over the years, the Court has endeavored to separate acts of private entities that faithfully can be considered state action from those that are necessarily private action, in order to protect a State from liability for conduct it could not control, yet impose liability when a State is "responsible" for the infringement of a plaintiff's constitutional or federal rights.[120] In essence, the principal question in state action analysis has been phrased by the Court as whether "there is such a close nexus between the State and the challenged action that seemingly private behavior may be fairly treated as that of the State itself."[121] The Court has most recently reiterated in *Brentwood Academy v. Tennessee Secondary School Athletic Association*[122] that the analysis of this standard is heavily fact-intensive.[123] The *Brentwood* Court employed several cases in an example-based approach to its analysis.[124] The most factually similar

116. *See* Flagg Bros., Inc. v. Brooks, 436 U.S. 149, 155-56 (1978) (citing Adickes v. S. H. Kress & Co., 398 U.S. 144, 150 (1970)).

117. *See id.*

118. *See id.*

119. *See* Rendell-Baker v. Kohn, 457 U.S. 830, 838 (1982); *see also* Brentwood Acad. v. Tenn. Secondary Sch. Athletic Ass'n, 531 U.S. 288, 295 n.2 (2001) (recognizing that conduct that is sufficient to meet the state action requirement of the Fourteenth Amendment also fulfills the requirement of action under color of state law for § 1983 claims).

120. *See Brentwood*, 531 U.S. at 295.

121. *Id.* (quoting Jackson v. Metro. Edison Co., 419 U.S. 345, 351 (1974)) (internal quotation marks omitted). The analysis of this standard has been generally referred to as "state nexus analysis." *See* G. Sidney Buchanan, *A Conceptual History of the State Action Doctrine: The Search for Governmental Responsibility*, 34 HOUS. L. REV. 333, 391 (1997) [hereinafter Buchanan, *Conceptual History I*]. I will also refer to the doctrine as state nexus analysis.

122. Brentwood Acad. v. Tenn. Secondary Sch. Athletic Ass'n, 531 U.S. 288 (2001).

123. *See id.* at 295-96 (explaining that the criteria of what is "fairly attributable" is not clear and a "host of facts" may apply to each analysis).

124. *See Brentwood*, 531 U.S. at 296 ("Amidst such variety, examples may be the best teachers. . . ."). For an excellent walkthrough of the labyrinth of state action jurisprudence, *see* Buchanan, *Conceptual History I*, *supra* note 121, and G. Sidney Buchanan, *A Conceptual History of the State Action Doctrine: The Search for*

case utilized by the Court, and indeed the most superficially similar Supreme Court case in state action jurisprudence to the case of the hypothetical plaintiff, is *Blum v. Yaretsky*.[125] By understanding *Blum* and its place in state action jurisprudence, the hypothetical plaintiff can assess the strength of her case.

1. *Blum* and the Story of the Totality Approach

*Blum* involved a class action suit brought by residents of privately-run nursing homes in the State of New York who received Medicaid assistance under 42 U.S.C. § 1396a and its corresponding regulations.[126] For a resident to receive Medicaid assistance, the federal regulations required that the services provided by the nursing home be medically necessary.[127] In order to ensure that the provision of services were medically necessary, the regulations required a proprietary utilization review committee ("URC"), composed of physicians unassociated with the facility, to determine periodically whether each resident was receiving appropriate care or whether transfer to a different level of care was warranted.[128] When the URC recommended a reduction in the plaintiffs' levels of care, it notified the state agency responsible for the reimbursement of services.[129] After state officials refused to reimburse the nursing home for further treatment of the plaintiffs at the same level of care, the plaintiffs filed suit, eventually arguing on appeal that the State "affirmatively commands the summary discharge or transfer of Medicaid patients" by nursing home physicians and administrators through the operation of several federal and state regulations.[130]

In a 7-2 decision written by Justice Rehnquist, the Court held firmly against the plaintiffs' arguments. The majority focused its holding on the ostensibly private decision-making of the nursing home physicians and administrators.[131] Despite federal regulations that threatened to exclude nursing homes providing excess services from participation in Medicaid, required state officials to review forms outlining each decision, and authorized a fine for providers who violated applicable regulations, the Court explained that the full power to decide whether an individual patient would be discharged or transferred to a different level of care

*Governmental Responsibility [Part II of II]*, 34 HOUS. L. REV. 665 (1997) [hereinafter Buchanan, *Conceptual History II*].

125. Blum v. Yaretsky, 457 U.S. 991 (1982).
126. *See id* at 994-95.
127. *Id.*
128. *Id.*
129. *Id.* at 995.
130. *Id.* at 995-96, 1005.
131. *See id.* at 1010.

rested in the hands of the physicians and administrators of the nursing homes.[132] In other words, the State was not "responsible for the specific conduct of which the plaintiff [complained]."[133] The Court stressed that discharge and transfer decisions were purely medical ones, uninfluenced by the action of the state, and to which the state merely responded by reducing or increasing Medicaid benefits in accordance with the nursing home's direction.[134] To the majority of the Court, the State did not exercise "coercive power" or provide "significant encouragement" to the private actors sufficient to label the private action as state action.[135]

The dissent, authored by Justice Brennan and joined by Justice Marshall, rebuked the majority's minimization and virtual disregard of the specific regulations involved in the decision-making process.[136] In a detailed opinion involving a step-by-step analysis of the applicable regulations, Justice Brennan proceeded to demonstrate how both the state and federal regulations were designed to save money for the Medicaid coffers by walking nursing home physicians and administrators through the determination of a patient's ideal level of care.[137] Justice Brennan further explained that Congress created lower-cost Medicaid facilities designed to provide "intermediate" care to patients unnecessarily being treated with "skilled" care.[138] Because the administration of state fiscal policy was delegated to private actors, Justices Brennan and Marshall argued that a patient-transfer decision by a nursing home simply could not be made "independently of the state regulatory standards. . . ."[139] Indeed, although patients could be transferred based upon a physician's independent medical recommendation, patients also were transferred as the result of URC reviews that involved a state-regulated grading and reporting system, as well as final approval by a state board.[140] To the

132. *See id.* at 1009-10.
133. *See id.* at 1004, 1005, 1008; *see also* Brentwood Acad. v. Tenn. Secondary Sch. Athletic Ass'n, 531 U.S. 288, 295 (2001) (citing *Blum* for the same standard).
134. *Blum*, 457 U.S. at 1010.
135. *See id.* at 1004 (stating the standard), 1008 (expressing the Court's judgment). *Brentwood* would later cite these factors from *Blum* as examples of an actionable nexus between the State and a private actor. *See Brentwood*, 531 U.S. at 296.
136. *See Blum*, 457 U.S. at 1012-29 (Brennan, J., dissenting).
137. *See id.*
138. *See id.* at 1014-16.
139. *Id.* at 1028-29.
140. *See id.* at 1024-27 (detailing the process and lucidly noting that "if the initial determinations were not made according to state-established standards and for the State's purposes, and were in fact 'independent' medical decisions as characterized by the Court, it is difficult to understand the State's active role in reviewing the substance of those determinations").

dissent, the State encouraged nursing homes enough to deem any private action as state action.[141]

With one exception,[142] the majority and dissenting opinions shift the balance of their discussions to the plaintiffs' argument that the State was a "joint participant" in the discharge and transfer of Medicaid patients.[143] In support of their argument, the plaintiffs relied on the Court's state action analysis in *Burton v. Wilmington Parking Authority*.[144] *Burton* has a special place in state action jurisprudence because it was the first case where the Court considered the totality of the contacts between the private actor and the State in its decision.[145] In *Burton*, the Court held that the action of a private restaurant located within a state-owned and operated parking garage was state action when the restaurant refused to serve an African-American while under a lease with the State.[146] The Court reasoned that the combination of the obligations and responsibilities attributable to the State as lessor, the mutual benefits arising from parking convenience and tax exemption, and the State's alleged benefit from the discrimination created such a degree of interdependence between the State and the private actor that the State had to be recognized as a joint participant in the discrimination.[147]

The relationship between the State and the nursing homes in *Blum* is more than comparable to the parking authority and restaurant in *Burton*. The *Blum* plaintiffs argued that, through Medicaid and licensing, the State ensured certain standards were met and effectively subsidized nursing homes by paying the health care expenses of over 90% of their residents.[148] Indeed, even more than the parking authority in *Burton* that simply provided maintenance and parking convenience for the restaurant's patrons, the privately-run nursing homes were virtually

141. *See id.* at 1028.

142. Before addressing the "joint participant" question, the majority opinion considers and discards the argument that the provision of nursing home care to the elderly is "traditionally [within] the prerogative of the State." *See id.* at 1011-12 (majority opinion). Although the dissent in *Blum* does not consider this issue, the Court in *Brentwood* considers private action traditionally in the prerogative of the State to be another important example of state action. *See* Brentwood Acad. v. Tenn. Secondary Sch. Athletic Ass'n, 531 U.S. 288, 296 (2001) (listing an example of state action as "when [a private actor] has been delegated a public function by the State"). For a further analysis of this standard, see discussion, *infra* Part III.B.2.

143. *See Blum*, 457 U.S. at 1010-11, 1027-28.

144. Burton v. Wilmington Parking Auth., 365 U.S. 715 (1961).

145. *See* Buchanan, *Conceptual History I*, *supra* note 121, at 395, 397. *See also Burton*, 365 U.S. at 724 (applying a totality approach to its analysis).

146. *See Burton*, 365 U.S. at 724-26.

147. *See id.* at 724-25.

148. *See Blum*, 457 U.S. at 1010-11.

sustained by the government's funding.[149] Moreover, unlike the *Burton* customers, whose minds were likely blind to the state's involvement in the discrimination at the restaurant, residents of the nursing homes were quite aware of the role of Medicaid in supporting their lives at the nursing homes, from paying for their food and shelter to regulating their level of care.[150] To the dissenting Justices in *Blum*, the degree of interdependence between the State and the nursing home was "far more pronounced" than the restaurant and state-run parking garage in *Burton*.[151] While the nursing homes relied on the State for profits and continued business, the State relied on the nursing homes to uphold the regulations that were theoretically in place to improve the quality of residents' lives.[152]

The majority quickly dismissed the issue. The Court reasoned that heavily regulated private businesses could not be analyzed under *Burton*, presumably because *Burton* did not involve a regulated business.[153] Additionally, the Court denied that substantial funding was a persuasive factor in determining the State's responsibility for the decisions of private actors.[154] By individually reviewing each factor and not considering the totality of the situation, the Court matched the style of reasoning in *Blum's* sister opinion, *Rendell-Baker v. Kohn*,[155] published the same term. In that case, five teachers and a counselor at a private school funded heavily by public sources and regulated by public authorities were discharged over a disagreement with a school director.[156] Like in the *Blum* opinion, the Court individually dismissed each factor, including the fact that the private school, like the nursing homes, also

149. *See id.* at 1027 (Brennan, J., dissenting) ("The private nursing homes of the Nation exist, and profit, at the sufferance of state and federal Medicaid and Medicare agencies. The degree of interdependence between the State and the nursing home is far more pronounced than it was between the State and the private entity in [*Burton*].").

150. *See id.* at 1027-28. There, Justice Brennan wrote:

> Even more striking is the fact that the residents of those homes are, by definition, utterly dependent on the State for their support and their placement. For many, the totality of their social network is the nursing home community. Within that environment, the nursing home operator is the immediate authority, the provider of food, clothing, shelter, and health care, and, in every significant respect, the functional equivalent of a State.

*Id.*

151. *See id.* at 1027.

152. *See id.* at 1027-28. Interestingly, the FNHRA solidified Justice Brennan's idealistic view on the regulations as intending to provide residents with the highest quality of life possible. *See supra* note 34.

153. *See id.* at 1011 (majority opinion) (citing Jackson v. Metro. Edison Co., 419 U.S. 345, 351 (1974)).

154. *Id.*

155. Rendell-Baker v. Kohn, 457 U.S. 830 (1982).

156. *Id.* at 834.

derived 90% of its funding from the State.[157] The *Rendell-Baker* and *Blum* opinions effectively put the totality approach to state nexus analysis crafted in *Burton* into hibernation.[158] Although the totality approach would awaken in the early 1990s,[159] the *Brentwood* Court chose not to explicitly include the approach in its analysis, instead adhering to its model of examples and applying the related concept of "entwinement."[160] Nonetheless, the totality approach to analyzing the contacts between the State and a private actor may still be invoked today.[161] Indeed, it only would require the appropriate facts. Does the hypothetical plaintiff have the right case? If not, does *Brentwood* suggest any other examples that may be appropriate?

2. The Applicability of *Blum*, *Burton*, and *Brentwood*

The first examples of state action cited by the *Brentwood* Court that may bear on a court's determination of the nexus between the State and the private actor are whether the State has exercised coercive power over the private actor and whether the State has significantly encouraged the actor to commit the challenged activity.[162] Both of these factors were central to the arguments in *Blum*.[163] The hypothetical plaintiff would quickly point out that the relationship between privately-run nursing homes, their respective states, and the federal government has grown substantially since the time of the *Blum* opinion. If anything, after the FNHRA were enacted in 1987, Congress increased the level of

157. *See id.* at 839-43.

158. *See* Buchanan, *Conceptual History I*, *supra* note 121, at 406 ("After the twin decisions in *Blum* and Rendell-*Baker*, if the totality approach was not dead, it was at least gasping for breath.").

159. *See* Georgia v. McCollum, 505 U.S. 42 (1992) (using *Edmonson's* reasoning to hold that a discriminatory peremptory challenge by a defendant was state action); Edmonson v. Leesville Concrete Co., 500 U.S. 614, 624 (1991) (using *Burton* as precedent to hold that a court enforcing a discriminatory peremptory challenge has voluntarily used its state power to support a violation of the Fifth Amendment Equal Protection Clause).

160. *See* Brentwood Acad. v. Tenn. Secondary Sch. Athletic Ass'n, 531 U.S. 288, 297 (2001) ("These examples of public entwinement in the management and control of ostensibly separate trusts or corporations foreshadow this case. . . ."). For a brief discussion of the entwinement factor, *see* discussion, *infra* Part III.B.2.

161. *See* Alan R. Madry, *Statewide School Athletic Associations and Constitutional Liability; Brentwood Academy v. Tennessee Secondary School Athletic Association*, 12 MARQ. SPORTS L. REV. 365, 391 (2001) ("Justice Souter took the conception and test of the state action doctrine decidedly back in the direction of the intuitive, ad hoc doctrine of the pre-Rehnquist Vinson and Warren Courts.").

162. *See Brentwood*, 531 U.S. at 296.

163. *See* Blum v. Yaretsky, 457 U.S. 991, 1008-10 (1982). The disagreement between the majority and dissent over the regulations centered on these two standards. *See* discussion, *supra* Part III.B.1.

regulation of the nursing home industry.[164] Furthermore, states still remain an integral part of the administration of Medicaid by contributing part of the necessary funds, managing the reimbursement system, and licensing facilities.[165] Finally, similar to the nursing home in *Blum* and the private school in *Rendell-Baker*, privately-run nursing homes continue to be funded substantially through Medicaid and Medicare reimbursement.[166]

Unfortunately for the hypothetical plaintiff, any argument advanced under the factors of coercion or significant encouragement would be ill-founded. Certainly, federal and state regulations are even more prevalent among nursing homes now than before 1987, but neither the majority nor dissent in *Blum* would find the regulations and private action involved here to have the fingerprints of the State. Unlike the federal and state regulations in *Blum*, which were designed to serve a state fiscal policy,[167] the state policy driving § 1396r is one of protection for the residents of certified nursing homes.[168] Essentially, the State, supporting regulations under § 1396r through Medicaid funding, is advising nursing home administrators of the rights that Medicaid recipients have. The hypothetical plaintiff might respond that the State is warning the nursing home administrators what *must* be done and thus coercing, or at least significantly encouraging, the nursing home operators to adhere to these regulations. However, this argument is misled because it ignores the action taken against the hypothetical plaintiff. When a nursing home commits the negligent actions that would lead to the hypothetical plaintiff's death, the nursing home is not acting in accordance with the regulations. In fact, the nursing home is acting in complete opposition to what the statute, regulations, and the inherent policy behind the legislation explicitly require. No court could find that such illegal activity was even in the most remote way coerced or significantly encouraged by the State.

Alternatively, the hypothetical plaintiff could turn to the *Burton* analysis for an appeal to the totality of the circumstances.[169] Certainly, a substantial relationship exists between the federal government, the State,

164. *See* discussion, *supra* Part II.A.
165. *See supra* notes 25, 42-44 and accompanying text.
166. In 2008, the percentage of total certified nursing home residents primarily paid for by Medicaid and Medicare was 77.65%. HARRINGTON, CARRILLO & WOLESLAGLE BLANK, *supra* note 18, at 18-19. The remaining 22.35% of residents primarily were supported by private funds. *Id.*
167. The majority agreed with the dissent that there was a driving state fiscal policy behind the regulations. *See Blum*, 457 U.S. at 1008 n.14 ("We do not suggest otherwise.").
168. *See supra* note 106.
169. *See* discussion, *supra* Part III.B.1.

and privately-run nursing homes.[170] Under the *Burton* paradigm, the important question is whether there is such a degree of interdependence between the State and the private actor as to consider the State a joint participant in the challenged action.[171] The hypothetical plaintiff could make a strong argument by relying on the same reasoning as the dissent in *Blum*.

The dissent in *Blum* reasoned that the relationship between the State and nursing homes was even more interdependent than the relationship between the State and restaurant in *Burton* because of the great level of state-funding and the pervasive state regulation of nursing home administration.[172] Certainly, the relationship between privately-run nursing homes and the State continues to involve heavy regulation, licensing, and substantial funding.[173] Although the primary source of funding for residents of privately-run nursing homes is less than 90% Medicaid and Medicare, as it was at the time of *Blum*, the current rate is still arguably a substantial amount.[174] Additionally, federal and state regulations continue to dominate the daily lives of nursing home residents, at least as much as they did at the time of the *Blum* decision.[175] Certainly, it is the position of this Comment that *Grammer* will transform the federal regulations from inconspicuously care-propelling standards to health care reforming rights, through active participation of residents in their own care. However, that is not to say that the regulations have not dominated the operation of nursing homes until the present and will not continue to do so in the future.[176] On the contrary, increased regulation and the double-check system of surveys between CMS, states, and nursing homes likely results in the pervasive influence of regulation upon daily life.[177] Finally, in 1987, Congress solidified its intent that § 1396r and the FNHRA provide the highest quality of life and care possible for residents.[178] With the intent of the State to control nursing home actions through pervasive regulations, the continued support of the industry

170. *See* discussion, *supra* Part II.A.
171. *See supra* note 147 and accompanying text.
172. *See supra* notes 151-152 and accompanying text.
173. *See* discussion, *supra* Part II.A.
174. *See supra* note 166 (The current percentage of residents whose primary source of payment is Medicaid or Medicare is 77.65%.).
175. *See supra* note 150 and accompanying text. As discussed, the FNHRA legislation only added more regulations and government oversight. *See* discussion *supra* Part II.A.
176. *See* Blum v. Yaretsky, 457 U.S. 991, 1028 (1982) (Brennan, J., dissenting) ("No one would doubt that nursing homes are pervasively regulated by State and Federal Governments; virtually every action by the operator is subject to state oversight." (internal quotation marks omitted)).
177. *See* discussion, *supra* Part II.C.
178. *See supra* note 34.

through Medicaid and Medicare funding, and the seeming dependency of the residents upon the State through the hands of the nursing homes, the situation is exactly what Justice Brennan warned about in his dissent in *Blum*: "Surely, in this context we must be especially alert to those situations in which the State 'has elected to place its power, property and prestige behind' the actions of the nursing home owner,"[179] for "when the State directs, supports, and encourages [private institutions with whom the State has chosen to achieve a policy] to take specific action, that action is state action."[180] The dissent was applying the totality approach from *Burton* to a new fact pattern with persuasive reasoning. So, too, the hypothetical plaintiff can develop her strongest § 1983 argument by appealing to the entire relationship between the State and nursing homes. However, there are two fatal blows to the hypothetical plaintiff's position. First, as discussed above, *Blum* is distinguishable from the hypothetical plaintiff's case because, in *Blum*, the federal and state regulations guided the nursing home's discharge and transfer decisions.[181] In the hypothetical plaintiff's case, the regulations establish resident rights, or in other words, serve as a warning to nursing homes that they violate their residents' rights at their own peril. Second, although the *Burton* totality approach was treated positively in two Supreme Court cases in the early 1990s,[182] other Court cases have cast doubt upon its scope.[183] Indeed, most applicable to the hypothetical plaintiff's case, the majority opinions in *Blum* and *Rendell-Baker* fully discarded the *Burton* totality approach.[184] Nonetheless, if the hypothetical plaintiff sought to apply the approach, the hesitation of a recent Third Circuit case to expand the scope of the test should deter her from arguing further.[185]

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179. *Blum*, 457 U.S. at 1028 (quoting Burton v. Wilmington Parking Auth., 365 U.S. 715, 725 (1961)).
180. *Id.*
181. *See id.* at 1008, 1026-27.
182. *See supra* note 159.
183. *See* Am. Mfrs. Mut. Ins. Co. v. Sullivan, 526 U.S. 40, 57-58 (1999) (emphasizing the following quote from *Blum*: "privately owned enterprises providing services that the State would not necessarily provide, even though they are extensively regulated, do not fall within the ambit of Burton."); NCAA v. Tarkanian, 488 U.S. 179, 192 (1988) (limiting *Burton's* scope to cases where the State "knowingly accepts the benefits derived from unconstitutional behavior"); Jackson v. Metro. Edison Co., 419 U.S. 345, 358 (1974) (explaining that the scope of *Burton* is limited to lessees of public property).
184. *See supra* note 158 and accompanying text.
185. *See* Crissman v. Dover Downs Entm't, Inc., 289 F.3d 231, 239-46 (3d Cir. 2002).

In *Crissman v. Dover Downs Entertainment, Inc.*,[186] casino employees excluded the plaintiffs from the casino premises for two years.[187] Charged with determining whether there was a sufficiently interdependent relationship between a Delaware casino and the State of Delaware under *Burton*, the Third Circuit held that, regardless of the heavy regulation and substantial flow of funds from casino to State, there was no state action because the State did not directly benefit from the exclusion of the plaintiffs from the casino nor did a state official make the decision.[188] The facts of *Crissman* more clearly define the scope of *Burton*. Although Justices Brennan and Marshall would balk at such an exiguous interpretation of the totality approach, it is likely best to keep *Burton's* scope narrow. Ultimately, as Justice Souter, writing for the majority in *Brentwood*, explained, "[no] set of circumstances [is] absolutely sufficient, for there may be some countervailing reason against attributing activity to the government."[189] Thus, a court likely would not find the hypothetical plaintiff's use of the totality approach to be compelling.

The *Brentwood* opinion cites several other axioms of state action jurisprudence, none of which have significant application to the hypothetical plaintiff's case. Privately-run nursing homes that violate rights under § 1396r certainly do not "willful[ly] participa[te] in joint activity with the State or its agents,"[190] because neither the State nor its agents are involved with the nursing home's violations. Similarly, even if a privately-run nursing home can be considered a "nominally private actor," in no way are the staff members or administrators of nursing homes "controlled by an agency of the State" when they violate § 1396r.[191]

A more involved question may arise regarding whether the privately-run nursing homes have been "delegated a public function by the State."[192] In state action jurisprudence, the question of public function has also been phrased as whether the private actor performs a function that is "traditionally the exclusive prerogative of the State."[193]

186. Crissman v. Dover Downs Entm't, Inc., 289 F.3d 231 (3d Cir. 2002).
187. *See id.* at 234-35.
188. *See id.* at 243-45; *see also id.* at 244 n.17 (listing five circuit decisions that held similarly).
189. Brentwood Acad. v. Tenn. Secondary Sch. Athletic Ass'n, 531 U.S. 288, 295-96 (2001).
190. *Id.* at 296 (internal quotation marks omitted) (citing Lugar v. Edmondson Oil Co., 457 U.S. 922, 941 (1982)).
191. *Id.* (internal quotation marks omitted) (citing Pennsylvania v. Bd. of Dirs. of City Trusts, 353 U.S. 230, 231 (1957) (per curiam)).
192. *Id.*
193. *See* Blum v. Yaretsky, 457 U.S. 991, 1011 (1982).

As was briefly mentioned, the *Blum* court had occasion to consider whether nursing home care has traditionally and exclusively been provided by the State and decided negatively.[194] Finding no constitutional or statutory authority requiring the State to provide nursing services to the elderly, the Court rejected the plaintiffs' argument.[195] Similarly, in the case of the hypothetical plaintiff, there is no constitutional or statutory authority that directs the State to provide elder care services. Additionally, further analysis can become meticulous.[196] Regardless, the hypothetical plaintiff simply does not have a non-frivolous argument because elder care has never been the exclusive responsibility of the State.[197]

Finally, the *Brentwood* case presents one other axiom of state action jurisprudence, "entwinement."[198] The Court explains that a nominally private actor is a state actor when "it is entwined with governmental policies or when government is entwined in its management or control."[199] In *Brentwood*, an interscholastic athletic association consisting of public school officials and State School Board members suspended a member school's athletic program in accordance with an Association rule prohibiting undue influence in athletic recruitment.[200] The member school sued the Association claiming that enforcement of the rule was state action under § 1983 and violated the Fourteenth Amendment.[201] The Supreme Court held that the Association was a state actor because it was entwined both "up" from public school officials and "down" from State School Board members by their capacities as officers of the Association.[202] The Court found that the entwinement was so

194. *See supra* note 142.

195. *See Blum*, 457 U.S. at 1011-12.

196. Even if there is statutory authority or ambiguous constitutional authority, a court still may not agree that the standard is met. *See id.* ("[Even if the State had such authority] it would not follow that decisions made in the day-to-day administration of a nursing home are the kind of decisions traditionally and exclusively made by the sovereign for and on behalf of the public."); *see also* Leshko v. Servis, 423 F.3d 337, 341-47 (3d Cir. 2005) (holding that foster care, although a traditional public duty, has never been an exclusive public function, and therefore foster parents are not state actors); *cf.* West v. Atkins, 487 U.S. 42, 54-58 (1988) (holding that a prison physician was a state actor when treating a prisoner because, inherently in the Eighth Amendment and state law, it has been the traditional and exclusive prerogative of the State to provide medical care for inmates).

197. *See supra* note 3.

198. *See supra* note 160 and accompanying text.

199. Brentwood Acad. v. Tenn. Secondary Sch. Athletic Ass'n, 531 U.S. 288, 296 (2001) (internal quotation marks omitted) (citing Evans v. Newton, 382 U.S. 296, 299, 301 (1966)).

200. *See id.* at 290-94.

201. *Id.* at 293.

202. *Id.* at 300-01.

"pervasive" that it rose to the point of "largely overlapping identity" between the Association and the State.[203]

Unfortunately for the hypothetical plaintiff, in her case, the same character of entwinement is impossible. Even if a court were to accept that the federal and state Medicaid regulatory scheme was so pervasive that it provided the necessary entwinement from the "top down," there is absolutely no "bottom up" entwinement from any privately-run nursing home administrators. No such administrators or staff could be considered public officials due to the private nature of the facilities. To be sure, as nursing homes aggregate into chains, it may be possible that state Medicaid officials could sit on Boards of Directors of such chains or Directors may hold state positions, but such a possibility is quite remote. Even so, the necessary entwinement would require many of such individuals sitting in conflicts of interest to reach the high threshold of the Association in *Brentwood*. The hypothetical plaintiff will not be able to obtain a default remedy under § 1983 for her rights under § 1396r. However, there still might be a remedy under the statute itself.

### C. *Do Residents of Privately-Run Nursing Homes Have a Private Cause of Action under § 1396r?*

Without a remedy under § 1983 for violations of her rights under § 1396r, the hypothetical plaintiff now turns to the statute itself for a remedy. Her executor may be surprised to know that a class of plaintiffs very similar to the decedent raised the same question in a federal district court in Georgia in 2000[204] and an executor for an individual plaintiff sued for the same issue in a federal district court in Pennsylvania in 2002.[205] Both of these cases share similar reasoning and interpret the same Supreme Court jurisprudence.[206] Even though these cases would not be mandatory precedent to another federal or state court deciding the hypothetical plaintiff's case, and the holding of the *Grammer* case may influence the court's analysis, the hypothetical plaintiff likely would not be able to convince a court that § 1396r provides a remedy to match her existing rights because there is no reason why the reasoning of the prior

203. *Id.* at 303.

204. Brogdon *ex rel.* Cline v. Nat'l Healthcare Corp., 103 F. Supp. 2d 1322, 1330-32 (N.D. Ga. 2000). The complaint alleged the existence of "inhumane conditions" at the nursing home that violated various provisions of § 1396r and § 1395i-3. *See id.* at 1325-26.

205. Sparr v. Berks County, No. 02-2576, 2002 U.S. Dist. LEXIS 13204, at *1-7 (E.D. Pa. July 18, 2002).

206. *See Brogdon*, 103 F. Supp. 2d at 1330-32; *Sparr*, 2002 U.S. Dist. LEXIS 13204, at *2-7.

courts is not still valid.[207] The remainder of this analysis will briefly examine how the reasoning of the *Brogdon* and *Sparr* courts likely would lead to the dismissal of the hypothetical plaintiff's claim.

The hypothetical plaintiff bears the burden of proving that Congress intended to imply a private cause of action under § 1396r.[208] In *Cort v. Ash*,[209] the Supreme Court instructed that a plaintiff in this context must convince the court (1) that the statute was created for the plaintiff's especial benefit; (2) that there is evidence of legislative intent to create a private remedy; (3) that a private remedy is consistent with the legislative purposes of the statute; and (4) that the area is not one traditionally relegated to state law.[210] In the end, the deciding court should agree that "Congress intended to create the private remedy asserted."[211]

The court in *Brogdon* began its analysis of the *Cort* factors by recognizing that the FNHRA likely were enacted for the benefit of a class of beneficiaries including the plaintiffs.[212] The court went so far as to propose that the FNHRA "may confer federal rights."[213] The *Sparr* court agreed that the statute was enacted for the plaintiff without further reasoning.[214] Certainly now, after the *Grammer* court held that § 1396r confers federal rights upon these types of plaintiffs,[215] this element of the *Cort* test is clearly in favor of finding an implied cause of action. Yet, as the *Brogdon* court pointed out, just because the plaintiffs have rights under a federal statute does not mean that Congress intended for the rights to be enforceable.[216]

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207. Despite the FNHRA legislation being passed, courts subsequently have decided against similar plaintiffs. *See Brogdon*, 103 F. Supp. 2d at 1331 ("An examination of the FNHRA does not alter this conclusion."). *See also* Prince v. Dicker, 29 F. App'x 52, 54 (2d Cir. 2002) (citing *Brogdon* and holding no implied cause of action); Wheat v. Mass, 994 F.2d 273, 276 (5th Cir. 1993) (holding same); Andrusichen v. Extendicare Health Servs., No. 02-674, 2002 U.S. Dist. LEXIS 13818, at *1-2 (E.D. Pa. July 23, 2002) (dismissing complaint in accordance with *Sparr*); Tinder v. Lewis Cty. Nursing Home Dist., 207 F. Supp. 2d 951, 956-58 (E.D. Mo. 2001) (holding that a resident has no private right of action under § 1396r).

208. *See Brogdon*, 103 F. Supp. 2d at 1330 (citing Suter v. Artist M., 503 U.S. 347, 363-64 (1992)).

209. Cort v. Ash, 422 U.S. 66 (1975).

210. *See Brogdon*, 103 F. Supp. 2d at 1330 (citing *Cort*, 422 U.S. at 78).

211. *Id.* (citing Transamerica Mortgage Advisors, Inc. v. Lewis, 444 U.S. 11, 15-16 (1979)).

212. *Id.*

213. *Id.*

214. *See* Sparr v. Berks County, No. 02-2576, 2002 U.S. Dist. LEXIS 13204, at *4 (E.D. Pa. July 18, 2002) ("Clearly, Plaintiff is one for whom the statute was enacted.").

215. *See* Grammer v. John J. Kane Reg'l Ctrs. – Glen Hazel, 570 F.3d 520, 530 (3d Cir. 2009).

216. *See Brogdon*, 103 F. Supp. 2d at 1330-31 (citing Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 18-19 (1981)).

The *Brogdon* court continued its analysis of the *Cort* factors by searching for evidence of legislative intent to create a private remedy in addition to the private right.[217] The court found that the legislative history of the FNHRA did not support a finding that Congress intended for an implied cause of action to exist.[218] The court noted that OBRA, of which the FNHRA are a part, is spending power legislation, which traditionally involves a contract-like agreement between the recipients of funds and Congress, to further congressional policy.[219] In the case of the FNHRA, the court found that the contract-like exchange was evident in excerpts from the House Reports, which indicated that Congress intended to further its policies by attaching certain conditions to the funding that would be enforced by CMS and state agencies.[220] Although the court admitted that the statute explicitly states that any remedies provided for should not be "construed as limiting [any] other remedies, including [those] at common law,"[221] it concluded that such language implied that Congress did not consider authorizing a private cause of action under the statute.[222] The *Sparr* court reasoned in the same manner, only adding that the length of Congress's discussion regarding the termination process of a noncomplying facility further indicates their intention to leave private causes of action to the common law.[223] The *Brogdon* court completed its analysis of the second factor by noting that the Medicaid Act was not modeled after a statute that contained an implied cause of action, like Title IX of the Education Amendments of 1972,[224] and furthermore, that the Medicaid Act is not designed to prevent discrimination.[225]

In response to these persuasive arguments, the hypothetical plaintiff might contend that the *Grammer* court's analysis of the "rights-creating language" in § 1396r is persuasive, as the court held that the language of

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217. *See id.* at 1331-32.

218. *See id.*

219. *See id.* at 1331.

220. *See id.* (citing HOUSE REPORT, *supra* note 29, at 452, 471 (explaining that the central purpose of the FNHRA is to improve residents' quality of life by bringing substandard facilities into compliance through enforcement or excluding them from funding)).

221. *See id.* (citing 42 U.S.C.S. §§ 1396r(h)(8), 1395i-3(h)(5) (LexisNexis 2010)). The House Report goes even further by stating that the common law remedies may include "private rights of action to enforce compliance with requirements for nursing facilities." HOUSE REPORT, *supra* note 29, at 472. This may suggest that Congress considered a private right of action and declined to include it in the statute.

222. *See Brogdon*, 103 F. Supp. 2d at 1331.

223. *See* Sparr v. Berks County, No. 02-2576, 2002 U.S. Dist. LEXIS 13204, at *4 (E.D. Pa. July 18, 2002).

224. 20 U.S.C. § 1681 (2006).

225. *See Brogdon*, 103 F. Supp. 2d at 1332.

§ 1396r "unambiguously" confers enforceable rights upon residents, like the rights-creating language in Title IX and Title VI unambiguously confers enforceable rights upon victims of discrimination.[226] Indeed, when the Supreme Court discerned an implied cause of action under Title IX, it found both a right and a remedy, allowing for a private cause of action under federal law.[227] Nevertheless, a court can distinguish § 1396r from the civil rights statutes. In *Grammer*, the Third Circuit considered only the existence of rights, and not the existence of a remedy, because any right would presumptively be enforceable under § 1983.[228] Although the two analyses are similar,[229] they still involve separate tests.[230] Thus, in sum, there simply is not enough evidence to suggest that Congress intended § 1396r to be more than a spending power statute that allows for § 1983 claims against state actors.[231]

The third element of the *Cort* analysis[232] was settled by the *Brogdon* court in favor of an implied cause of action under § 1396r.[233] Because of Congress's intent to improve the residents' quality of care and the explicit statutory recognition of common law remedies, the *Brogdon* court found that a private remedy would be consistent with the legislative scheme.[234] Although the *Sparr* court agreed that Congress was concerned with the quality of care in nursing homes, it argued that the primary legislative purpose of the Medicaid Act is to direct the use of

226. Grammer v. John J. Kane Reg'l Ctrs. – Glen Hazel, 570 F.3d 520, 531 (3d Cir. 2009).

227. *See generally* Cannon v. Univ. of Chicago, 441 U.S. 667, 689-717 (1979).

228. *See Grammer*, 570 F.3d at 525 n.2.

229. *See* Gonzaga Univ. v. Doe, 536 U.S. 273, 284-85 (2001) ("[T]he initial inquiry—determining whether a statute confers any right at all—is no different from the initial inquiry in an implied right of action case. . . ." (citing California v. Sierra Club, 451 U.S. 287, 294 (1981))).

230. *See id.* at 283 ("We have recognized that whether a statutory violation may be enforced through § 1983 is a different inquiry than that involved in determining whether a private right of action can be implied from a particular statute." (internal quotation marks omitted) (citing Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498, 508 n.9 (1990))).

231. *See* Brogdon *ex rel.* Cline v. Nat'l Healthcare Corp., 103 F. Supp. 2d 1322, 1332 (N.D. Ga. 2000) (determining that § 1396r has nothing more than the "components of a typical funding statute"). Additionally, there is no reason to suggest that *Grammer's* finding of federal rights under § 1396r alters the analysis of Congress's intent to create a private cause of action under the statute.

232. The Supreme Court has instructed that the third and fourth elements of the *Cort* test should not be broached unless the first two elements suggest that Congress intends to provide a private cause of action under the statute. *See Sierra Club*, 451 U.S. at 298 (citing Touche Ross & Co. v. Redington, 442 U.S. 560, 574-76 (1979)). Even though the *Brogdon* court does not address this aspect of the *Cort* analysis, I will apply all four elements of the test because the first element is strongly in favor of an implied cause of action and the *Brogdon* court considered all four elements of the test in its opinion.

233. *See Brogdon*, 103 F. Supp. 2d at 1332.

234. *Id.*

federal funds by states.[235] Consequently, the *Sparr* court concluded that an implied cause of action would be inconsistent with the purposes of § 1396r.[236] The court did not explain why an implied cause of action had to be consistent with the *primary* purpose of the statute, nor did it explain why improving the standard of care in nursing homes must be a secondary purpose of § 1396r.[237] Regardless, in the hypothetical plaintiff's case, the *Brogdon* court's interpretation of the purposes of § 1396r is strengthened by *Grammer's* determination that residents have rights under § 1396r. Logically, it would follow that if Congress implied rights under a statute, it would be more likely to consider an implied right of action concerning those rights as consistent with the statute. Furthermore, the *Grammer* court specifically found that the terms of § 1396r "do not focus on the entity regulated rather than the individuals protected," but on "the persons benefitted."[238] This finding is in direct contradiction to the *Sparr* court's interpretation of § 1396r.[239] Nevertheless, the impact of this reasoning on the final balancing of the *Cort* test is likely insignificant because the *Brogdon* court already found that this element was in favor of an implied cause of action.

The final element of the *Cort* analysis asks whether the implied cause of action infringes upon an area of the law traditionally relegated to the states, such that it would be "inappropriate to infer a cause of action based solely on federal law."[240] Citing *City of Boerne v. Flores,*[241] which remarked that states traditionally have the prerogative "and general authority to regulate for the health and welfare of their citizens,"[242] the *Brogdon* court determined that health and welfare legislation is indeed traditionally relegated to the states.[243] The *Sparr* court fully agreed with *Brogdon's* analysis and conclusion.[244] Although it would not be difficult for the hypothetical plaintiff to argue against a Supreme Court opinion's observation, it would be much more difficult to contend that a federal implied cause of action would not conflict with the

235. *See* Sparr v. Berks County, No. 02-2576, 2002 U.S. Dist. LEXIS 13204, at *5-6 (E.D. Pa. July 18, 2002) (citing Chalfin v. Beverly Enters., 741 F. Supp. 1162, 1167 (E.D. Pa. 1989)).
236. *See id.*
237. *See id.*
238. Grammer v. John J. Kane Reg'l Ctrs. – Glen Hazel, 570 F.3d 520, 529-30 (3d Cir. 2009).
239. *See supra* notes 235-237 and accompanying text.
240. *See* Cort v. Ash, 422 U.S. 66, 78 (1975).
241. City of Boerne v. Flores, 521 U.S. 507 (1997).
242. *Id.* at 534.
243. *See Brogdon*, 103 F. Supp. 2d at 1332.
244. *See* Sparr v. Berks County, No. 02-2576, 2002 U.S. Dist. LEXIS 13204, at *6-7 (E.D. Pa. July 18, 2002).

authority of the state to promulgate common law causes of action.[245] Indeed, that particular concern is likely what inspired the Supreme Court to fashion the final element of the test to ask whether a cause of action is appropriately educed based solely on federal law.[246] The quintessential example of a cause of action that is appropriately based solely on federal law is a suit brought under Title IX for gender discrimination because state law has not traditionally been responsible for protecting individuals from discrimination.[247] Thus, it is likely that a future court would agree that the analysis of the final element of the *Cort* test weighs against finding an implied cause of action under § 1396r for the hypothetical plaintiff.

After considering all of the elements of the *Cort* test, the *Brogdon* and *Sparr* courts held that insufficient evidence existed to prove that Congress intended to create a private cause of action that would allow a resident like the hypothetical plaintiff to sue a privately-run nursing home to enforce her rights under § 1396r.[248] While the *Grammer* holding does strengthen the hypothetical plaintiff's arguments that § 1396r was enacted for her especial benefit and that an implied cause of action would be consistent with the legislative scheme, the assistance is trivial compared to the potency of the remaining elements. The hypothetical plaintiff does not have enough evidence to prove that the legislative history intended to confer a private remedy and create a private cause of action. Furthermore, the fact that the health and welfare of citizens has traditionally been the prerogative of the states creates a gargantuan hurdle for the hypothetical plaintiff to overcome. Faced with these seemingly insurmountable arguments, the hypothetical plaintiff likely will reflect on the practicality of even raising them in court. Ultimately, it becomes a value judgment, and playing a large role in the hypothetical plaintiff's decision will be the fact that she does not need a private cause of action under § 1396r to seek full redress for her injuries. Indeed, various state law claims provide her with ample opportunities for redress and § 1396r may be used to establish the standard of care in negligence or third-party beneficiary breach of contract claims.[249] Thus, although it is arguably in the best interests of the plaintiff to raise every possible cause of action to maximize recovery, here, it is likely in the

245. For examples of state common law causes of action in this context, *see supra* note 22.

246. *See City of Boerne*, 521 U.S. at 534.

247. *See Brogdon*, 103 F. Supp. 2d. at 1332 (citing Cannon v. Univ. of Chicago, 441 U.S. 677, 708 (1979)).

248. *See id.*; *Sparr*, 2002 U.S. Dist. LEXIS 13204, at *6-7.

249. *See supra* note 22; *see also Brogdon*, 103 F. Supp. 2d at 1332-37 (denying several motions to dismiss state law claims).

best interests of the hypothetical plaintiff to focus her efforts on appropriate state law claims and using § 1396r as the standard of care where applicable.

## IV. CONCLUSION

In a nursing home world supported by Medicaid and Medicare, for-profit chains continue to dominate the landscape while residents of both privately-run and state-run nursing homes continue to suffer from federally-unacceptable levels of care. As CMS and state agencies continue to perform a role in the protection of these residents, so do the courts. In *Grammer*, the Third Circuit continued to fulfill its role as a protector by inferring a cause of action under § 1396r for residents of state-run nursing homes and reminding residents of privately-run nursing homes that the federal government also considers them a protected class. Although privately-run nursing homes almost certainly cannot be considered state actors and a private cause of action for residents of such homes under § 1396r is very difficult to infer, these resident-plaintiffs should be content in knowing that they have many avenues for redress. In the end, it is much more preferable to avoid stretching state action jurisprudence and creating implied causes of action than it is to grant worthy plaintiffs unnecessary relief. With luck, the Third Circuit's recognition of resident rights under § 1396r will inspire nursing home residents and their families to actively participate in elder care, holding all facilities responsible for the care that they provide. If the *Grammer* opinion invokes this type of response from nursing home residents, Congress's intention to improve the quality of life in nursing homes will be fulfilled.