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Ruqaiijah A. Yearby
Saint Louis University School of Law

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Article

***429 STRIVING FOR EQUALITY, BUT SETTLING FOR THE STATUS QUO IN HEALTH CARE: IS
TITLE VI MORE ILLUSORY THAN REAL?**

[Ruqaiijah Yearby \[FNa1\]](#)

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*430 Julia Morgan sought to place her 76-year-old uncle, Elmer Price, in a nursing home. Mr. Price suffered from arthritis in his arms and legs, walked with a cane, had poor eyesight, and was starting to show signs of senility. He had \$15,000 in savings and a supplemental insurance policy that would assist with his nursing home payment. On March 8, 1995, Ms. Morgan visited a nursing home and asked to speak with someone in admissions. She was directed to a social worker at the nursing home. When asked about the availability of a bed, the social worker told her that there was a waiting list, but didn't know how many people were on the waiting list. She suggested that Ms. Morgan return later in the morning to talk to the executive director about the waiting list. That afternoon Ms. Morgan returned to the nursing home and asked to speak with the executive director. The executive director stated that the nursing home had rooms available, but they were reserved for patients who were in the hospital. She added that there were four people on the waiting list. Although Mr. Price was a private pay patient, the executive director advised Ms. Morgan that her uncle would have to be approved by Medicare or Medicaid, and described some of the social activities that occurred at the nursing home.

As Ms. Morgan was leaving, she passed Janice Popowich. Ms. Popowich sought placement for her 78-year-old father-in-law, John Popowich. Mr. Popowich suffered from some memory loss, used a walker, and was hard of hearing. He had approximately \$10,000 in savings and social security income of just over \$500 per month. Like Ms. Morgan, Ms. Popowich was directed to the social worker for assistance with placing her father-in-law. The social worker inquired whether Mr. Popowich would qualify for Medicaid and took the time to explain Medicaid payments to Ms. Popowich. When Ms. Popowich inquired about the availability of a bed, the social worker informed her that she was uncertain about the waiting list because the administrative office handled it. When Ms. Popowich requested to speak with someone in that office, the executive director appeared within a

few minutes to speak with her. Only a short time after Ms. *431 Morgan left, the executive director told Ms. Popowich that a bed was available immediately in the private pay section of the nursing home. The executive director said that the nursing home could admit Mr. Popowich within two to four days. [FN1]

Even though their cultural differences, payment status, manner of seeking admission, physical condition, neighborhood of residency, and educational level were the same, the nursing home only offered a bed to Mr. Popowich. The only difference in the information given to the nursing home was their race. Mr. Price is African American and Mr. Popowich is White. The nursing home submitted several reasons for this disparate treatment. [FN2] First, the nursing home said that cultural differences kept them from offering the room to Mr. Price. The facility served mostly Hungarian residents who did not speak English, attended Hungarian religious services, and enjoyed Hungarian cultural services. According to the facility, Mr. Price, an African American, did not fit in. However, Mr. Popowich was neither Hungarian nor did he speak any other language than English. Second, the nursing home said that the difference in payment status was an issue because it was unclear whether Mr. Price would have qualified for Medicaid, while it was apparent that Mr. Popowich would have qualified for Medicaid. Upon admission both potential residents were private pay patients, and based on their assets they would have qualified for Medicaid at the same time. Additionally, Mr. Price had supplemental insurance that would have paid more to the facility than the Medicaid payments used by Mr. Popowich. Finally, the nursing home noted that it did not admit patients through walk-in admissions, rather it obtained residents from hospital or community referrals. Nevertheless, Mr. Popowich was a walk-in patient, who sought admission as Ms. Morgan was leaving, and was offered a bed immediately. Two decades of empirical data show that this story is a common occurrence, not simply an isolated *432 incident. [FN3] Many legal and medical experts assert that the most likely explanation for Mr. Price's lack of equal access to quality nursing home care is racial discrimination. [FN4] But how can this be the case forty-two years after the passage of Title VI?

Title VI of the Civil Rights Act of 1964 prohibits nursing homes receiving Medicare and/or Medicaid from using race to deny admission or quality care to African Americans. [FN5] Nevertheless, decades' worth of research studies show that African Americans are systematically denied equal access to quality nursing homes because of their race. [FN6] This evidence has been submitted to the federal government in the form of research findings [FN7] and in the form of *433 complaints against the perpetrating nursing homes. [FN8] Unfortunately, the United States government has done little to put an end to these practices even though Title VI prohibits racial discrimination. [FN9] Thus, one must ask whether the governmental protections offered by Title VI are more illusory than real in the health care industry.

I. Introduction

Prior to 1964, racial segregation and discrimination in health care was government funded under the Hospital Survey and Construction Act, better known as the Hill-Burton Act. Specifically, section 622(f) of the Hill-Burton Act proscribed federal funding for "separate but equal" health care services. [FN10] The United States tried to put an end to racial discrimination in the health care system by intervening in a private action that challenged the constitutionality of the Hill-Burton Act [FN11] and with the enactment of Title VI of the Civil Rights Act of 1964, which banned racial discrimination in health care for institutions receiving federal funding. [FN12] As a tactic to make health care entities end racial discrimination, the government coupled the requirements of Title VI with participation in the Medicare and Medicaid programs. Before health care entities could become eligible for Medicare and Medicaid funding, the government had to certify the entities' compliance with Title VI. [FN13] Each action was a blow to the pervasive de jure segregation emblematic of a Jim Crow United States. However, ample evidence shows that the federal government has consistently and systematically failed to enforce Title VI to prohibit racial discrimination in health care. This failure has culminated in the continuation of

separate and unequal health care services, resulting in racial inequities in health care. The consignment of African Americans to unequal health services is illustrated by racial inequities faced by elderly African Americans. By reviewing the health inequities faced by elderly African Americans, this paper will show that the central reason for the continuation of these inequities is racial discrimination.

***434** Raised during the Jim Crow era of legalized racial discrimination, elderly African Americans remain subject to lingering vestiges of de facto racial discrimination in the health care system, blocking their access to necessary health care services and causing racial inequities in care. [FN14] Studies have shown that in 1950, before the end of Jim Crow, the life expectancy rates of African American men and White men over the age of sixty-five was the same. [FN15] Since 1950, elderly African Americans' life expectancy has continued to decline even after the advent of Title VI, which granted them "equal" access to health care services. [FN16] African Americans' lack of equal access to quality health care is instrumental in higher mortality rates. For example, more African Americans have died from coronary disease, breast cancer, and diabetes than Whites, [FN17] even though more Whites suffer from these diseases than African Americans. Even if elderly African Americans survive the lack of equal access to quality health care, this lack of access significantly compromises their health condition as evidenced by their overuse of services for untreated chronic conditions.

Under Medicare, the only health services elderly African Americans have greater access to than Whites are for services to care for untreated conditions, such as the removal of tissue for late stage pressure sores. [FN18] The overuse of these services leaves elderly African Americans more disabled than Whites and requires them to obtain more assistance conducting activities of daily living, [FN19] such as dressing, eating, and showering. [FN20] Assistance for these activities is provided by the long-term care system through home health care agencies, nursing homes, and assisted living facilities. Empirical studies of the long term care system show that there are significant ***435** racial inequities in the quality of care provided elderly African Americans by the long term care entities, such as nursing homes.

In fact, two decades of empirical studies demonstrate that elderly African Americans are on average two times more likely to reside in poor quality nursing homes than Whites. [FN21] This is a result of some quality nursing homes systematically denying admission to African Americans, [FN22] relegating African Americans to substandard nursing homes. [FN23] Research studies show that African Americans' access to necessary rehabilitative treatment provided by quality nursing homes is impeded because of their race. [FN24] These studies found that African Americans face longer delays in transfer to nursing homes, because some White residents either implicitly or explicitly request only White roommates and some nursing homes acquiesce to these requests by denying admission to African American patients. [FN25] Denied from admission to these quality nursing homes, most elderly African Americans only gain access to poor quality nursing homes. [FN26] Even if African Americans gain access to quality nursing homes, national studies show that African American "nursing home residents are less likely to receive medically appropriate treatments, ranging from cardiovascular disease medication to pain medication to antidiabetes drugs" [FN27] than Whites residing in the same nursing home. Researchers and jurists have offered innumerable "neutral" reasons [FN28] to explain the continuation ***436** of these racial inequities in health care, including cultural differences, [FN29] geographic racial segregation, [FN30] and socioeconomic status. [FN31] However, for at least decades, researchers have noted that regardless of their gender, education, or socioeconomic status, African Americans lack equal access to quality health care compared to Whites. [FN32] Legal and medical experts assert that the most likely explanation for African Americans' lack of equal access to quality nursing home care is racial discrimination in the form of both disparate treatment and disparate impact. [FN33]

This evidence has been submitted to the U.S. Department of Health and Human Services ("HHS"), [FN34]

the governmental agency in charge of enforcing Title VI in health care, in the form of research findings [FN35] and private complaints against the perpetrating nursing homes. [FN36] However, little has been done to put an end to these practices even though Title VI prohibits racial discrimination. [FN37] Underfunded and understaffed, the Office of Civil Rights (“OCR”), *437 the division of HHS responsible for enforcing Title VI, [FN38] has never terminated a nursing home proven to have violated Title VI in its thirty-seven year history. [FN39] Moreover, OCR does not collect racial or admission flow data, regulate nursing homes' admission practices, or survey the racial makeup of nursing homes. [FN40] Without collecting data, regulating admission practices, or surveying nursing homes, OCR is poorly situated to prohibit racial discrimination in nursing homes, which prevents elderly African Americans from obtaining equal access or quality. [FN41] Consequently, the burden of solving this problem has been left to elderly African Americans and their advocates, who have sought to rectify these discriminatory practices by suing the perpetrators for violation of Title VI. [FN42] Often little direct evidence is available in the long-term care field showing intentional discrimination. Therefore, most cases have centered on the theory of disparate impact and Medicaid bias. [FN43] Nevertheless, the United States put an end to private Title VI claims asserting discrimination through disparate impact with the Supreme Court's decision that Title VI only granted private individuals the right to sue for *438 intentional racial discrimination. [FN44] The duty to rectify disparate impact cases in health care was left to OCR, which to date has never filed a lawsuit under Title VI to protect minorities from racial discrimination in health care. [FN45] Therefore, the Supreme Court's ruling that there is no private right of action has left federal government agencies with the responsibility of addressing racial discrimination, but to date government reports show that the agencies have failed to pursue effective measures to prevent racial discrimination. [FN46] Congress has not stepped in to address the failure of federal administrative agencies to enforce Title VI, and the federal courts have ruled against private parties trying to induce federal administrative agencies to enforce Title VI. [FN47] Left with no avenue to rectify disparate impact discrimination through federal courts or through regulatory action, African Americans have henceforth been relegated to poor quality, segregated nursing homes.

In the past, scholars have suggested incremental approaches that the government could use to improve Title VI compliance, such as revising Title VI regulations and policies and applying the standards from disability law to Title VI jurisprudence. [FN48] The government has failed to adopt any of these suggestions, so the time has come for elderly African Americans and their advocates to induce the government to diligently enforce Title VI by pursuing legal solutions that are likely to be more efficacious. Professor Dayna Bowen Matthews has suggested using the False Claims Act to sue government entities for falsely certifying compliance with Title VI as a method to put an end to racial discrimination and collect money for *439 the aggrieved parties. [FN49] In the same vein as this inventive suggestion, I propose the use of the Medicaid Act, the Fair Housing Act, and the International Convention on the Elimination of All Forms of Discrimination (“CERD”). First, elderly African Americans can file actions against the federal government for failing to provide African Americans with quality nursing home care, a violation of the Medicaid Act. [FN50] Second, elderly African Americans could file actions against offending nursing homes under the Fair Housing Act for denying access to housing based on race. [FN51] Finally, a complaint could be submitted to the United Nations under CERD for the failure of the United States to prevent racial discrimination in health care. [FN52] Each of these solutions possesses a different strength and weakness, which the author will further discuss in more detail in future articles. Nevertheless, without any action on the part of elderly African Americans and their advocates, the issue of racial discrimination in health care will remain unchanged as it has for the last forty-two years.

This article uses empirical data and government reports to examine the government's disregard for elderly African Americans' *440 right to equality in health care by using the problems with the long-term care system as a case study. Section II reviews the history of de jure discrimination in health care institutions. The government's solution to eradicate racial discrimination in the health care system is examined in Section III. One of the

government's solutions was the enactment of Title VI, which prohibits racial discrimination. Forty-two years after the enactment of Title VI, racial discrimination is still pervasive in health care as evidenced by empirical data. The continuation of de facto racial discrimination in health care is examined in Section IV, and the failure of the government to eradicate this discrimination is discussed in Section V. Finally, Section VI suggests solutions to encourage the federal government to diligently enforce Title VI, unlike prior legal jurisprudence, which proscribed possible private rights of action under Title VI. [FN53]

II. De Jure Segregation and Disparate Treatment: The History of Racial Segregation and Discrimination in Health Care

A review of the history of health care in the United States reveals that numerous developments in medical technology, [FN54] health insurance products, [FN55] and health care institutions [FN56] were due to racial segregation and discrimination. Scholars note that modern gynecological techniques were mastered on slave women, [FN57] the development of private health insurance was to ensure the defeat of racially integrated government insurance, [FN58] and the development of private hospitals ensured the racial segregation of patients. [FN59] The influence of racial discrimination in the development of the health care system in the United States was so pervasive that even the federal government promoted racial segregation with the passage of the Hill-Burton Act to fund separate but equal health care services. [FN60] During the Civil Rights era, racial segregation changed from de jure *441 to de facto, while racial discrimination evolved from disparate treatment to disparate impact. Illustrative of the historical shift in the United States from de jure to de facto segregation and from disparate treatment to disparate impact racial discrimination is a review of the evolution of the long-term care system during the twentieth and twenty-first centuries. Reviewing the history of racial segregation and discrimination in long term care is important to crafting a solution to the current discriminatory practices used by the long-term care system as well as in the entire health care system.

Throughout the development, regulation and funding of nursing homes, some form of racial segregation and discrimination has been present. In the 1800s, the nursing home system was segregated based on class. Rich Whites were housed in private charitable facilities, while poor Whites were housed in county or public general hospitals, psychiatric hospitals, poor houses, and poor farms. [FN61] African Americans were not even allowed to take part in this system until 135 years later. [FN62] African Americans received their care from families regardless of whether they were slaves or not.

With the passage of the Social Security Act of 1935 ("SSA"), the federal government established federal funding for the elderly under the Old Age Assistance Program, [FN63] but prohibited public institutions from receiving Old Age Assistance payments. [FN64] Hence, only private institutions housing the elderly, i.e., nursing homes, could receive payment under this program. This prohibition was particularly significant because in the 1930s the health care system was racially separated based on whether the institution was public or private. [FN65] Most African Americans received their care at public institutions, while Whites received their care at private institutions. [FN66] Because public institutions were prohibited from receiving SSA funding, the passage of the SSA served as a means to foster the segregation of races in the long-term care system. [FN67] With the influx of cash, private nursing homes developed to consist of acute care or geriatric wings in private hospitals for the rich Whites, and private boarding houses for *442 poor and disabled Whites. [FN68] Racial segregation in the long term care system was further exacerbated by the enactment of the Hospital Survey and Construction Act of 1946, better known as the Hill-Burton Act. [FN69] Although, the Hill-Burton Act provided funding for the construction of public health care institutions, such as hospitals that provided care to African Americans, equality was not achieved because the federal government authorized the use of intentional racial discrimination.

The Hill-Burton Act allotted funding for the construction of hospitals and granted states the authority to regulate this construction. Hospitals used this funding to construct, among other things, nursing home wards and freestanding geriatric hospitals to care for the elderly, the precursors to current day nursing homes. [FN70] The Act also provided that adequate health care facilities be made available to all state residents without discrimination of color. [FN71] This language seemingly granted adequate funding without discrimination, but section 622(f) negated this promise. Section 622(f) of the Hill-Burton Act stated:

[S]uch hospital or addition to a hospital will be made available to all persons . . . but an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group [FN72] Thus, the Act was designed to induce the states, through financial support, to supervise, regulate, and maintain the placement of adequate racially segregated hospital and nursing home facilities throughout their territory. [FN73] To accomplish this goal, the states had to review all applications for funding and submit a detailed plan to the Surgeon General for authorization of funding. [FN74] Under section 622(f) of the Hill-Burton Act, states could opt to participate in the federal program based on a separate but equal plan providing for segregated facilities. [FN75] Fourteen states submitted “separate but equal” applications to the Surgeon General, who then reviewed the *443 States' plans to ensure that there was equitable distribution of funding. [FN76] The Surgeon General accomplished the goal of keeping health care institutions segregated, but the equitable distribution of funding was never realized. [FN77] The inequitable use of African Americans' tax money for the construction of health care facilities from which they were barred was commonplace under the Hill-Burton Act. Thus, the federal government's funding of public institutions did not equalize the dichotomy of racial segregation in health care developed under the SSA, particularly in the long-term care system.

In the 1960s, the federal government unsuccessfully tried to address such racial discrimination in the health care system in three specific ways: intervening in the *Simpkins v. Moses H. Cone Memorial Hospital* [FN78] case, passing the Civil Rights Act of 1964, and passing the Medicare and Medicaid Acts. However, the failure of the federal government to consistently and systematically enforce the laws prohibiting racial discrimination has culminated in the continued de facto segregation of elderly African Americans to substandard nursing homes.

III. The Promise of a Dream: Preventing Racial Segregation and Discrimination in Health Care

Throughout the 1960s, African Americans waged national and international battles to obtain the rights of full citizenship in the United States. [FN79] The civil rights movement focused on equality of rights in every area of life, including the right to quality health care. The disenfranchisement of African Americans seeking health care did not change until African Americans forced the government to comply with the Constitutional mandates of the Equal Protection Clause of the 14th Amendment. [FN80] In 1962, African Americans filed a racial discrimination lawsuit against hospitals in North Carolina receiving Hill-Burton funding. [FN81] The federal government intervened on behalf of the plaintiffs and further tried to eradicate racial discrimination with the passage of Title VI of the Civil Rights Act of 1964 and the Medicare and Medicaid Acts. [FN82] The Medicare and *444 Medicaid programs provided extra federal funding to make Title VI compliance attractive to nursing homes. The language of Title VI requires that nursing homes in receipt of federal funding do not discriminate. Nevertheless, the funding was not enough to induce nursing homes' compliance with Title VI and the dream of equality has been denied to elderly African Americans once again.

A. Private Action and Government Intervention

Seven years after the Supreme Court's landmark decision in *Brown v. Board of Education* [FN83] ended racial segregation in public schools, a group of African American physicians, dentists, and patients filed a federal suit styled as *Simpkins v. Moses H. Cone Memorial Hospital*. [FN84] Filed in the state where the most racially segregated hospital were located, [FN85] the case challenged the legality of two North Carolina hospitals' [FN86] receipt of Hill-Burton funding to construct hospitals that provided racially discriminatory care. Using the Equal Protection Clause of the 14th Amendment as a basis, the plaintiffs challenged the constitutionality of section 622(f) of the Hill-Burton Act that authorized racial discrimination. [FN87] This case is noteworthy for two reasons. First, the case established that health care entities funded by the government, customarily subject to government regulation, were state actors. Second, it established the government's funding of health care entities that discriminated based on race was unconstitutional.

First, the court ruled that the hospitals were state actors and, thus, violated the Equal Protection Clause of the 14th Amendment when denying access to care by race. [FN88] The court based its decision on *445 the fact that the hospitals received millions of dollars worth of federal funding to construct hospitals. [FN89] Moreover, the court held that the "hospitals operate as integral parts of comprehensive joint or intermeshing state and federal plans or programs designed to effect a proper allocation of available medical and hospital resources for the best possible promotion and maintenance of public health." [FN90] Hence, health care entities receiving Hill-Burton Act funding were deemed to be state actors or public institutions subject to government regulation. As state actors, the health care entities were prohibited by the Equal Protection Clause of the 14th Amendment from racially discriminating against African Americans.

Second, the court ruled that the "separate but equal" language in the Hill-Burton Act, authorizing the use of federal funds to construct racially separate health care facilities, was unconstitutional. [FN91] The court's finding was in part due to the intervention of U.S. Attorney General Robert F. Kennedy on behalf of the African American parties. The Attorney General argued that the government, both state and federal, had authorized and sanctioned the hospitals' racial discrimination perpetrated against the plaintiffs with the passage of section 622(f) of the Hill-Burton Act. [FN92] The court made a point of noting the persuasiveness of this argument in its invalidation of the "separate but equal" language. [FN93] The hospitals appealed the case to the Supreme Court, which denied certiorari.

The *Simpkins* case was important to the civil rights movement because it provided a broad definition of state actors that included those regulated by and receiving funding from the government. Additionally, it was significant that the court ruled that it was unconstitutional for the government to fund a "separate but equal" health care system. Not only did the government incorporate these rules of law into federal civil rights legislation, but it also referred specifically to the *Simpkins* case as it debated the passage of Title VI of the Civil Rights Act of 1964. [FN94] Congress passed Title VI to prohibit racial discrimination in health care and made compliance mandatory *446 before health care entities could receive any Medicare and Medicaid funding. Notwithstanding these efforts, the federal government's failure to enforce Title VI, which prohibits government-funded racial discrimination, has led to the proliferation of racially discriminatory practices in health care, particularly in the long-term care system. In fact, Professor David Barton Smith's research has shown that nursing homes never fully racially integrated or actively sought African American patients. [FN95] The only change was the removal of blatantly discriminatory advertising. [FN96] Thus, the federal government's choice to put an end to racial discrimination through funding rather than through enforcement has backfired, making Title VI's promise of equality more of an illusion than reality.

B. Title VI of the Civil Rights Act

On June 19, 1963, when the Civil Rights Act was first introduced, President John Kennedy said in a message to Congress:

Events of recent weeks have again underlined how deeply our Negro citizens resent the injustice of being arbitrarily denied equal access to those facilities and accommodations which are otherwise open to the general public. That is a daily insult which has no place in a country proud of its heritage-- the heritage of the melting pot, of equal rights, of one nation and one people. No one has been barred on account of his race from fighting or dying for America--there are no 'white' or 'colored' signs on the foxholes or graveyards of battle. Surely, in 1963, 100 years after emancipation, it should not be necessary for any American citizen to demonstrate in the streets for the opportunity to stop at a hotel, or to eat at a lunch counter in the very department store in which he is shopping, or to enter a motion picture house, on the same terms as any other customer. [FN97] Enacted in memorial to President Kennedy, the passage of the Civil Rights Act was a monumental feat. [FN98] Congress enacted the Civil Rights Act of 1964 banning racial discrimination in housing, employment, and health care. Title VI of the Civil Rights Act was the vehicle used by Congress to put an end to discrimination in health care. [FN99] One member of Congress noted that Title VI "represented the moral sense of the Nation that there should be racial equality in *447 Federal assistance programs." [FN100] Title VI provides both a private right of action and mandates for government enforcement. The private right of action is found in section 601, [FN101] which reads:

No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. [FN102]

This language prohibits racial discrimination by health care facilities funded by the federal government. [FN103] Private parties have a right to sue health care facilities that violate section 601 based on intentional racial discrimination that prevents participation or the access to benefits under federally funded health care programs. [FN104] Congress delegated the task of eradicating racial discrimination in health care to HHS. The mandates of enforcement for HHS are found in section 602, which states:

Each Federal department and agency which is empowered to extend Federal financial assistance to any program or activity, by way of grant, loan, or contract other than a contract of insurance or guaranty, is authorized and directed to effectuate the provisions of section 2000d [section 601] of this title with respect to such program or activity by issuing rules, regulations, or orders of general applicability which shall be consistent with achievement of the objectives of the statute authorizing the financial assistance in connection with which the action is taken. [FN105]

Section 602 of Title VI requires HHS to undertake measures to ensure that those health care entities receiving federal funding, such as nursing homes, do not discriminate on the basis of race, color, or national origin. [FN106] To achieve racial integration in health care, Title *448 VI of the Civil Rights Act requires the Secretary of HHS to promulgate regulations prohibiting federal funding of nursing home and requiring written assurances of nondiscrimination from nursing homes. [FN107]

HHS promulgated Title VI regulations on December 4, 1964. [FN108] In 1967, HHS created the Office of Civil Rights ("OCR") to be the primary civil rights office for HHS and enforce these Title VI regulations. [FN109] The director, who is the head of OCR and the Special Assistant to the Secretary for Civil Rights, reports directly to the Secretary of HHS. [FN110] OCR has one headquarter office and ten regional offices and is organized into two departments: the Office of Management Planning and Evaluation and the Office of Program Operations. [FN111] The regional offices conduct Title VI complaint investigations and preaward reviews and report to the Office of Program Operations. [FN112] These Title VI compliance investigations and reviews are all based on the Title VI regulations. In fact, health care entities are prohibited from:

Utiliz[ing] criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin. [FN113]

This regulation forbids health care entities from using neutral policies that have the effect of subjecting African Americans to racial discrimination or impairing their ability to access quality health care. To ensure that health care entities are complying with these *449 mandates, OCR is required to review compliance reports and collect “racial and ethnic data showing the extent to which members of minority groups are beneficiaries of and participants in federally-assisted programs.” [FN114]

Notwithstanding these strong enforcement mandates of the statutory and regulatory language of Title VI to eradicate racial discrimination, the promise of Title VI has proven to be illusionary. To enforce Title VI, section 602 provides the government with the right to terminate or refuse funding to a noncompliant nursing home, but:

[N]o such action shall be taken until the department or agency concerned has advised the appropriate person or persons of the failure to comply with the requirement and has determined that compliance cannot be secured by voluntary means. In the case of any action terminating, or refusing to grant or continue, assistance because of failure to comply with a requirement imposed pursuant to this section, the head of the Federal department or agency shall file with the committees of the House and Senate having legislative jurisdiction over the program or activity involved a full written report of the circumstances and the grounds for such action. No such action shall become effective until thirty days have elapsed after the filing of such report. [FN115] Thus, Congress sought compliance first through voluntary means and left only the choice of termination from all federal health care programs as a remedy. The failure of Congress to provide remedies or sanctions, other than termination, for the violation of Title VI has severely restricted the regulation of health care entities under Title VI. [FN116] Moreover, requiring HHS to first seek voluntary compliance after a violation has been proven renders Title VI little more than a *450 guide to what should happen, and not a law that one must obey. With limited enforcement mechanisms available under Title VI, Congress relied on the attractiveness of extra funding from participation in the Medicare and Medicaid programs to entice health care entities to comply with civil rights requirements. However, in most cases the prospect of additional funding has done little to spur nursing homes to adopt racially neutral admission and provision of care policies. [FN117]

C. Medicare and Medicaid Acts

With the enactment of Title VI of the Civil Rights Act of 1964, the right to equal enjoyment and access to health care became the subject of federal government regulation. [FN118] Using its spending power, Congress made compliance with Title VI mandatory before a nursing home could become eligible to receive Medicare or Medicaid funding. [FN119] Enacted in 1965, the Medicare [FN120] and Medicaid [FN121] Acts increased federal funding to all health care entities, including nursing homes. Medicare pays for sundry health care services provided to the elderly and consists of three parts: Part A (Hospital Insurance), Part B (Supplemental Medical Insurance), and Part C (Medicare Managed Care). [FN122] Part A covers nursing home care for persons over the age of sixty-five if they are placed in a nursing home within thirty days of being in the hospital for three or more consecutive days, or after longer than thirty days when medically necessary. [FN123] Medicare covers up to one hundred days of care received at a nursing home. [FN124] Once Medicare coverage runs out, Medicaid will cover medically necessary nursing home services for the elderly. [FN125] Medicaid provides reimbursement for nursing home care for indigent elderly, but is also used by affluent elderly patients that spend down their resources. Medicaid eligibility for the elderly differs significantly by state, but once a patient qualifies for Medi-

caid, the *451 state will pay for nursing home services until a patient leaves the nursing home. [FN126]

Medicare and Medicaid funding was instrumental in putting an end to racial discrimination in hospitals across the country. Faced with the loss of a substantial revenue stream, most hospitals integrated overnight. [FN127] Nursing homes, however, were not interested in government funding and the government was not dedicated to forcing racial integration. [FN128] During the 1960s and 1970s, the time and eligibility requirements of Medicare did not provide steady income for nursing homes and the low reimbursement rates of Medicaid caused many nursing homes to forgo participation in the programs. [FN129] Instead, nursing homes sought private pay patients. [FN130] Furthermore, the government was reluctant to force Whites and African Americans to live together in nursing homes. [FN131] Compared to hospitals, the government viewed nursing homes as private residences, and thus did not actively enforce racial integration. [FN132] Professor David Barton Smith found that “[t]he nursing-home industry concluded that so long as discriminatory practices were not flaunted, there would be no intervention by federal officials.” [FN133] In 1967, when nursing home enrollment in Medicare began, most homes were still “owner-operated converted houses” and viewed more as private residences than health care entities. [FN134] Therefore, as long as nursing homes made a good faith effort by marketing with nondiscriminatory language and submitting written assurances of *452 nondiscrimination, the government certified nursing homes that continued to use racial discriminatory practices to participate in Medicare and Medicaid. [FN135]

By the 1980s, any racial integration based on the lure of federal funding was obliterated by government cutbacks in response to rising health care costs. [FN136] The government initiated cutbacks even though studies showed that to achieve racial integration of health care entities, such as nursing homes, the states needed to increase reimbursement rates for Medicaid. [FN137] The inability of the government to induce nursing homes to racially integrate with the passage of the Medicare and Medicaid Acts was not the government's only failure. By the time nursing homes began participating in these programs, the issue of Title VI enforcement was no longer a focal point of the government, and African Americans have henceforth been relegated to substandard quality, [FN138] segregated nursing homes. [FN139]

The quality of Medicare and/or Medicaid certified nursing homes is evaluated by state health agencies conducting annual recertification inspections of each Medicare and/or Medicaid certified nursing home. [FN140] This recertification process is called “survey and certification.” [FN141] Under the current “survey and certification” system, once a nursing home is certified to participate in Medicare or Medicaid, the home is visited every nine to fifteen months [FN142] by a state health agency survey team comprised of, among others, nurses, nutritionists, social workers, and physical therapists. [FN143] The team assesses whether the nursing home continues to be in compliance with the Medicare and/or Medicaid regulations. [FN144]

*453 If the survey team finds the nursing home out of compliance with the Medicare or Medicaid regulations, it cites the facility for a deficiency, [FN145] and assigns a scope and severity level to the deficiency based on the egregiousness of the offense. [FN146] The scope is the number of residents affected and the severity level refers to the seriousness of the harm. [FN147] The severity level includes actual harm and serious actual harm posing a risk of death (immediate jeopardy). [FN148] This means that the more egregious the deficiency, the poorer the quality of the nursing home. African Americans tend to reside in poor quality nursing homes. [FN149] The findings are sent to HHS for approval, but do not include racial data concerning the residents affected by the deficiencies. [FN150] Once HHS approves the findings of noncompliance, it imposes sanctions, makes the findings public, and notifies the state long-term care ombudsman, the physicians and skilled nursing facility administration licensing board, and the state Medicaid fraud and abuse control units. [FN151] However, HHS does not track racial inequities regarding the victims of the deficiencies to ensure that both African Amer-

icans and Whites receive equal care. In fact, there is no system by which HHS surveys and certifies that quality care is provided without regard to race, in spite of the dictates of Title VI and the intent of the Medicare and Medicaid Acts.

With the passage of Title VI, Medicare, and Medicaid, many civil rights activists believed that the fight for equality had been won. They were sorely mistaken. The dream of equality that so many civil *454 rights activists worked for remained unfulfilled because of the government's lack of commitment to enforce the law. Without this commitment, some nursing homes have continued business as usual, discriminating and segregating by race as illustrated by two decades of empirical studies and government reports.

IV. The Continuation of Racial Segregation and Discrimination in Nursing Homes

In 2000, nursing homes provided care to 1.5 million elderly and disabled persons, and by 2050 nursing homes are projected to provide care to 6.6 million elderly and disabled persons. [FN152] Between 2000 and 2030, the elderly African American population will grow by 168%, while the elderly population of Whites will grow by only 90%. [FN153] Traditionally, elderly African Americans need more access to long-term care services to fulfill their daily activities, such as showering, toileting, and eating. [FN154] Elderly African Americans' access to health care services is severely restricted compared to their White counterparts, [FN155] regardless of socioeconomic status and health insurance. [FN156]

Studies show that elderly African Americans are among the most vulnerable members of society because of their lack of access to health care services. [FN157] Elderly African Americans are less likely to receive breast cancer screening, eye examinations for patients with diabetes, beta-blocker medication after heart attack, and follow-up treatment after hospitalization for mental illness. [FN158] The lack of access to health care services directly affects the health care status of elderly African Americans, causing them to over use services to care for untreated conditions, evidenced by a study of Medicare usage. For *455 example, elderly African Americans have higher rates of pulmonary disease [hypertension], diabetes, circulatory problems, and arthritis than Whites. [FN159] Even though African Americans have higher rates of diabetes, they have less access to leg-sparing surgery than leg amputation surgery. [FN160]

Under Medicare, the only health services elderly African Americans have greater access to than Whites are for services to care for untreated conditions, such as amputations from diabetes, removal of testes from prostate cancer, removal of tissue from late stage pressure sores, and implantation of shunts for renal disease. [FN161] African Americans have greater access to these services than Whites even though the number of African Americans suffering from these ailments is less than the number of Whites. [FN162] Therefore, it is imperative that elderly African Americans be granted equal access to quality long-term care services. Government studies have shown that elderly African Americans “use nursing homes 20 percent less than aged Whites, with the gap growing to 40 percent among those aged 85 and over.” [FN163]

Based on the abovementioned data, it is clear that racial inequities remain ubiquitous in the long term care system. There have been a number of “neutral” reasons suggested for these racial inequities, such as cultural differences, [FN164] geographic racial segregation, [FN165] and socioeconomic status. [FN166] All of these factors play a role in the continuation of these racial inequities; however, empirical data and government reports suggest that racial discrimination remains the central reason for these inequities. [FN167] Research shows that racial inequities continue when these “neutral” factors are controlled, which only racial discrimination, however defined, *456 explains. [FN168] A review of the nursing home system serves as an example of the ills of the entire health care system. Scholars note that nursing homes remain more racially segregated than hospitals,

[FN169] and illustrate that racial discrimination continues to prevent African Americans from accessing quality health care service regardless of socioeconomic status, education, or health insurance status. The discrimination is institutionalized and accomplished through delaying transfer and denial of admission of elderly African Americans to quality nursing homes.

During the first research studies of nursing home quality in the 1980s, researchers found that African Americans received unequal quality as a result of transfer delays [FN170] and admission to poor quality nursing homes. [FN171] Studies show that African Americans were delayed transfer to quality nursing homes because of their race. [FN172] The inequities caused by transfer delays are further exacerbated by racial discrimination in nursing home admission policies. Even when payment status is controlled, there is a disparity in the number of African Americans admitted to quality nursing homes compared to the number of Whites admitted to the same nursing homes. [FN173]

Once African Americans gain admission to a nursing home, their physical condition is further compromised by the poor quality of care provided. The number of Medicare deficiencies was two times higher in predominately African American nursing homes versus predominately White nursing homes. [FN174] These inequities in quality are found not only in the difference in quality of nursing homes to which African Americans are admitted versus the nursing homes to which Whites are admitted, but also in the differences in the quality of care received when they reside in the same nursing home. National studies show that African American “nursing home residents are less likely to receive medically appropriate treatments, ranging from cardiovascular disease medication to pain medication to *457 antidiabetes drugs” [FN175] than Whites residing in the same nursing home.

The continuation of these racial inequities in the quality of nursing home care, which are not explained by geographical racial segregation or socioeconomic status, shows that the government has not fulfilled its promise to end racial discrimination in the health care system. The failure of the United States to put an end to these racially discriminatory health care practices that violate Title VI suggests that the prohibitions against racial discrimination in Title VI are more illusionary than real.

A. Denial of Equal Access

African Americans are denied equal access to quality nursing home care by delay in transfer and denial of admission to quality nursing homes. Elderly patients gain admission to nursing homes through transfer from hospital care or from home. Frequently, elderly patients are transferred to a nursing home after a hospital stay. [FN176] The decision to transfer a patient from a hospital to a nursing home is controlled by the patient's physician and the hospital's discharge staff. [FN177] A transfer normally occurs once a physician determines that a patient is well enough to be released from the hospital, but not well enough to go home. [FN178] A member of the hospital discharge staff contacts the nursing home seeking to transfer a patient. Minorities are customarily delayed in transfer to quality nursing homes. [FN179] A delay in transfer is “the time elapsed between when a patient was medically ready for discharge to another form of care and when he or she actually was discharged.” [FN180] Delays in transfer to nursing homes deny patiental access to medically necessary rehabilitative care. Research studies in several states have shown that African Americans experience transfer delays to quality nursing homes because those nursing homes deny admission to African Americans. [FN181]

*458 Since the 1980s, several state studies have shown that African Americans are delayed by at least ten days in a transfer from the hospital to a nursing home. [FN182] This delay is because African Americans have “difficulty in finding alternative placement.” [FN183] Statistical analysis of transfer data suggests that African Americans' failure to find a nursing home placement was not correlated with the patient's payment source, phys-

ical condition, demographic attributes, family cooperativeness, or behavioral issues. [FN184] Race was the central factor in the transfer of patients from the hospital to a nursing home. [FN185] According to the authors of the study, Professors David Falcone and Robert Broyles, the fact that race is the greatest predictor of delay in transfer and that there has been no change in this delay even once brought to the attention of those responsible for transfers, proves that racial discrimination is the cause of the delays. [FN186] Further research shows that, because there are fewer African Americans in nursing homes than Whites, [FN187] African American patients are delayed transfer to nursing homes until they can be placed in the same room with other African Americans or can be transferred to predominately African American nursing homes. [FN188] Hence, racial discrimination is also present in the admission practices and policies of nursing homes, which remain unregulated by both the state and federal governments.

States administering federal entitlement programs (Medicaid and Medicare) are supposed to regulate the admission processes of nursing homes. [FN189] However, if states were to regulate admissions and increase racial integration, the costs of Medicaid would increase. [FN190] Trying to keep down the costs of Medicaid, states grant nursing homes great discretion in their admission practices and policies. [FN191] Thus, in reality, the admissions decisions are left solely to the nursing home staff. [FN192] Nursing homes have used this discretion to deny admissions to African American patients, as shown by several state studies.

In 1988, Doctors William Weissert and Cynthia Cready found that there was a significant delay in transfer of African Americans from hospitals to nursing homes in North Carolina. [FN193] This delay was because some White nursing home residents wanted to room with those of the same race. [FN194] To comply with this request, nursing homes intentionally kept rooms and their facility segregated by denying admittance to African Americans. [FN195] In 1984, a study of New York nursing homes showed that nursing homes that provided excellent quality of care demonstrated a pattern of admitting Whites over African Americans. [FN196] Statistics showed that the population of quality nursing homes was one-third White, while one-half of the population of the substandard quality nursing homes was predominately African American. [FN197] This disparity was attributed to “a combination of discrimination by nursing homes and steering by hospital discharge planners.” [FN198]

The New York State Advisory Committee to the U.S. Commission on Civil Rights (“Advisory Committee”) reviewed nursing home admission practices in New York eight years later and found that there were still significant racial inequities in admission between African Americans and Whites. [FN199] The Advisory Committee's findings showed that White patients were three times more likely to get into a quality nursing home than minority patients. [FN200] Of the characteristics used to decide whether to admit a patient, race remained the chief factor, even in nursing homes sponsored by religious organizations, which were more likely to admit those of a different religious background than those of a different race. [FN201] Based on this evidence, the Advisory Committee found that discriminatory admission practices had been institutionalized in the admission policies and procedures of New York nursing homes causing a disparate impact on African Americans. [FN202] The inequities in admissions practices are significant because where a patient is admitted usually determines the quality of care that patient receives. [FN203] Statistics from a study of New York nursing homes showed that nursing homes that provide substandard care are predominately African American. [FN204]

B. Denial of Equal Quality

The quality of nursing home care is defined by the health of the residents and by the nursing home's compliance with quality of care regulations under the Medicare and Medicaid Acts. [FN205] When comparing the quality of care African Americans receive in nursing homes with the quality of care Whites receive in that same

nursing home, the inequities are significant. [FN206] Additionally, racial inequities in the quality of care provided in predominately African American nursing homes compared to predominately White nursing homes are evidenced by a plethora of research studies over the last decade. [FN207]

A study of several states, including New York, Kansas, Mississippi, and Ohio found that when Whites and African Americans reside in the same facility the quality of care provided is different. [FN208] African Americans traditionally receive poor quality care. [FN209] For example, the standardized admission resident assessment tool (required by the government to be completed within fourteen days of a resident's admission) [FN210] showed that late-stage pressure sores are more common to African Americans, while early stage pressure sores are more common to Whites. [FN211] African Americans have higher rates of late-stage pressure sores because *461 they are commonly underdiagnosed. [FN212] Thus, Whites receive treatment before the pressure sore becomes too severe, while African Americans and other minorities suffer without treatment until the pressure sore becomes severe. [FN213]

In addition to these racial inequities in care when Whites and African Americans reside in the same facility, there are significant inequities when the races reside in different nursing homes. According to national data compiled from Medicare forms, African Americans reside in nursing homes with “lower ratings of cleanliness/maintenance and lighting.” [FN214] Moreover, African Americans are twice as likely to be admitted to primarily Medicaid paying nursing homes, which are then twenty-four percent more likely to have deficiencies. [FN215] The facilities whose primary source of payment is Medicaid are traditionally of poor quality and predominately house African Americans. [FN216]

In a recent national study of nursing home quality, researchers deemed facilities whose primary source of payment is Medicaid as “low-tiered facilities.” [FN217] The researchers called Medicaid-only facilities low-tiered facilities because of their poor quality. [FN218] Forty-one percent of predominately African American nursing homes are low-tiered facilities. [FN219] This study showed further that nine percent of Whites reside in low-tiered facilities compared to forty percent of African Americans that reside in low-tiered facilities. [FN220] African Americans are three to five times more likely to be in low-tiered facilities than Whites. [FN221] The placement of a majority of African Americans in low-tiered facilities is significant because these nursing homes are more likely to be terminated from the Medicaid/Medicare program because of quality of care deficiencies. [FN222] These low-tiered facilities have fewer nurses, more quality of care deficiencies, higher incidences of pressure sores, use physical restraints more, and have *462 inadequate pain control and use of antipsychotic medications. [FN223] Hence, the admission of African Americans to low-tiered facilities has subjected them to substandard nursing home care. This national data is further supported by a study conducted in St. Louis, which showed that St. Louis nursing homes were racially segregated and those predominately African American had more deficiencies, i.e., violations of Medicare and Medicaid regulations. [FN224]

Overall, a review of the empirical data provides a dismal picture of the accessibility of quality nursing home care available to elderly African Americans. African Americans are delayed access to medically necessary rehabilitative care because nursing homes are unwilling to admit them for treatment. Even when African Americans finally gain access to nursing homes the quality of care is substandard. A number of barriers exist preventing African Americans from accessing quality health care: cultural differences, geographical racial segregation, socioeconomic status, and racial discrimination. Each factor may play a role in explaining this conundrum, but the abovementioned research studies and government reports show that African Americans face delays in transfer and denial of admission to quality nursing homes even when cultural differences, geographical racial segregation, and socioeconomic status are controlled. The only factor that remains predictive of the inequity in accessing quality care is race.

C. Reasons for Delay and Denial of Equality

Innumerable reasons have been offered to explain the continuation of these health inequities, including cultural differences, [FN225] geographic racial segregation, [FN226] socioeconomic status, [FN227] and racial discrimination. [FN228] It is clear that these reasons, taken together, have caused racial inequities in accessing quality health care services. However, when each factor is controlled the biggest predictor of lack of access to quality health care is race. [FN229]

*463 First, the theory of cultural differences has been proffered by scholars, like Professor Steven Wallace, as one reason for the current inequities in accessing nursing home services. [FN230] Some researchers speculate that African Americans tend to use more family care than nursing home care because of their cultural beliefs. [FN231] However, studies conducted by the Institute of Medicine and Professor Jim Mitchell show that there is little cultural difference between elderly African Americans and Whites in their choice to use institutional care. [FN232] Cultural differences seem to play a bigger part in Whites' decisions to deny admittance to African Americans to quality nursing homes than African Americans preferences to stay at home.

According to researchers, elderly Whites do not want to room with African Americans because of “cultural differences,” and, therefore, African Americans are denied admission to quality nursing homes because of their “cultural difference.” [FN233] Unfortunately, these “cultural differences” actually mean racial differences. [FN234] For example, a religiously based nursing home in Ohio was not very receptive to admitting African American patients because the nursing home specialized in providing culturally sensitive services to elderly Hungarian patients. [FN235] However, the nursing home admission staff was receptive to non-Hungarian Whites who did not share the same culture as their other residents, leaving one to wonder if the cultural difference was simply a racial difference. [FN236] This use of “cultural difference” to mask racial discrimination is not limited to this nursing home in Ohio; it has appeared in New York. [FN237] In fact, since 1984, studies have shown that religiously based nursing homes in New York are more willing to admit Whites from different religious backgrounds than African Americans. [FN238] According to research studies, the most segregated nursing homes in New York *464 are voluntary religious facilities. [FN239] Thus, the theory of cultural differences seems to be used by many nursing homes as a proxy to deny admission to African Americans because of their race, rather than a choice by African Americans to forgo nursing home care.

Second, Professor Steven Wallace has suggested that geographical segregation is the fundamental cause of racial inequities in nursing homes. [FN240] Specifically, African Americans are placed in poor quality nursing homes because that is all that is available in the neighborhoods in which they live. [FN241] However, a study of four states showed that, for three of the states, this was not the case. [FN242] In Mississippi, New York, and Ohio, census data showed that the percentage of African Americans residing in predominately White neighborhoods was much higher than the population of African Americans residing in nursing homes in that neighborhood. [FN243] The researchers found that the racial segregation in nursing homes in these three states was greater than the surrounding geographical racial segregation, and thus concluded that geographical segregation could not fully explain racial segregation in nursing homes in these states. Intentional racial discrimination by the nursing homes was also the reason for the racial inequities in admission to nursing homes.

Even if geographical racial segregation is one of the reasons for racial inequities in admission to nursing homes, numerous legal and medical scholars, including Professors Steven Wallace and David Williams, have still shown that one of the fundamental reasons for the continuation of geographical racial segregation is racial discrimination. [FN244] Studies have shown that “explicit discrimination in housing persists” as “[t]here has been little change in [the] levels of segregation in the last 20 years.” [FN245] This racial segregation is not self-*465 imposed by African Americans, as they “reflect the highest support for residence in integrated neigh-

borhoods.” [FN246] The abovementioned research suggests that some of the nursing home admission staff in predominately White neighborhoods use a combination of racial geographic segregation and racial preferences to keep out African Americans. Hence, regardless of when one views the problem of racial inequities in health care, whether at the point of selection of residence in the neighborhood or at the point of selection of residence in a nursing home, racial discrimination is a barrier to African Americans gaining access to safe, quality health care.

Finally, some scholars argue that the lower socioeconomic status of African Americans is the ultimate reason for racial inequities in health care. [FN247] Throughout the medical literature a battle has raged for the last three decades concerning the significance of race and socioeconomic status in creating inequities in health care. [FN248] Even as this debate continues, no researcher would deny that even when socioeconomic status is controlled, racial inequities still remain that are not explained by educational level, geographic location, or disease status. [FN249] Professor Steven Wallace even notes, “The patterns of institutional practices based on race in hospitals and nursing homes . . . suggests that a class-based approach alone will not *466 eliminate differences in the health care provided to older Blacks.” [FN250] Nevertheless, scholars maintain that socioeconomic status is central to nursing home admission because private pay patients are preferred over Medicare or Medicaid patients. [FN251] This theory is contrary to studies, which show that White Medicaid patients entering into a nursing home experience less of a delay than African American patients. [FN252] In North Carolina, Medicaid patients experienced a one-day delay on transfer to a nursing home while African Americans experienced a three-day delay regardless of payment status. [FN253] This delay in transfer was due to the admission practices of some quality nursing homes, which chose to admit White patients and deny African Americans. [FN254] This decision was made without thought to financial status.

Professors Mary Fennel and David Barton Smith's work show that race is a better predictor of residing in a substandard nursing home than socioeconomic status. [FN255] Even Professor Steven Wallace recognized the failure of socioeconomic status to explain the problems of racial inequity in New York nursing homes. [FN256] In New York, Whites resided in one-third of the quality nursing homes, while minorities resided in half of the poor quality public nursing homes. [FN257] Because the institutions were funded by the same payment source, Medicaid, the pattern was ascribed to racial discrimination. [FN258] Instead of being the source of the disparity in admission to quality nursing homes, socioeconomic status seems more like the proxy. [FN259] Nursing homes use payment status as a means to deny beds to African Americans using Medicaid, but simply certify another bed as Medicaid if presented with a White patient. [FN260] Because of this data, researchers have concluded that even if differences in socioeconomic *467 status were addressed, there would still remain racial inequities in the provision of nursing home care. [FN261]

Four main barriers have been suggested to explain why racial inequities in health care persist: cultural differences, [FN262] geographic racial segregation, [FN263] socioeconomic status, [FN264] and racial discrimination. [FN265] It is clear from the literature that no one factor has been accepted as the central reason for the inequities. A review of the nursing home system and its problems suggests that racial discrimination is the central reason for racial inequities in accessing quality nursing home care. First, the only cultural difference noted by studies is that some Whites prefer not to room or be in a facility with African Americans. [FN266] Second, racial segregation in quality nursing homes was greater than the geographical racial segregation in the neighborhood. [FN267] Third, even when socioeconomic status was controlled, racial inequities in access to quality nursing homes persisted. Finally, a review of the literature discussing the causes for the geographical racial segregation and socioeconomic status of African Americans identifies racial discrimination as one of the reasons for the continuation of the ills of African Americans. If racial inequities in the quality of nursing home care are not caused by cultural differences, geographical racial segregation, or socioeconomic status, why is racial discrimin-

ation the culprit?

Based on empirical research, race remains the central barrier to elderly African Americans accessing quality nursing home care. African Americans in North Carolina were delayed 3 to 10.7 days in transfer to nursing homes. [FN268] In Pennsylvania, elderly African Americans were delayed in transfer for months because they could not find a nursing home to accept them, and they had to reside in the *468 hospital. [FN269] The delays in transfer result from a denial of admission to quality nursing homes. Research studies in New York and St. Louis show that race remains the greatest predictor of accessing quality nursing home care. White patients were three times more likely to be admitted to a quality nursing home than were African Americans. [FN270] Based on this research, race remains the central factor in accessing nursing home care, but do these practices violate Title VI?

Title VI prohibits both disparate treatment and impact [FN271] because of race, and specifically outlaws the denial of benefits because of race. [FN272] According to two decades of research and government reports, some nursing homes have consistently violated Title VI by using race to deny benefits to African Americans. In two different studies of North Carolina nursing homes, researchers showed that elderly African Americans were delayed access to medically necessary services because of their race. [FN273] In the first study, the research found that the nursing homes denied admission to African Americans based on the rooming preferences of their patients. [FN274] If White patients did not want to room with African American patients, then no African American patients were admitted until a match could be found. [FN275] Usually, no match could be found, so African Americans were forced to remain in hospitals or shipped to predominately African American nursing homes, which tend to be substandard homes. [FN276]

In the second study, Professors David Falcone and Robert Broyles found that the racial discrimination went beyond this *469 matching decision. [FN277] They discovered that discrimination in transfer delays took “three different forms all of which are institutionalized and have an adverse disparate impact on African Americans.” [FN278] First, there is “passive discrimination” that “refers to the practice of acceding to others' discriminatory preferences.” [FN279] This racial discrimination is morally reprehensible, against the law, and costly for the government. When a patient is delayed in being transferred from the hospital to a nursing home, the hospital bears the cost, which is then passed on to the government. [FN280] Second, there is “entrepreneurial discrimination” based on the preferences of residents or reactions of the market. [FN281] Third, there is “cultural distinctiveness” discrimination. [FN282] This is the misconception that racial groups prefer to be with people of their own kind. The need to stay in business is used to explain the untenable practice of keeping African American residents limited to a small number, to attract prospective or actual residents. [FN283] Regardless of the type of racial discrimination, all three of these forms of discrimination lead to the same outcome: The delayed transfer of African Americans from hospitals to nursing homes because African Americans are denied admission to quality nursing homes based on race. Thus, nursing homes' use of race to deny African Americans access to medically necessary rehabilitative services is a violation of Title VI. Consequently, although there may be a number of factors that cause racial inequities in health care, the central reason is the continuation of racial discrimination in health care in violation of Title VI.

The majority of this research, which has been reported to the government, shows that some government-funded nursing homes continue to violate Title VI. [FN284] Although these findings of racial discrimination in health care have been presented to the state and federal governments, nothing has been done. In the case of New York, the problems were first presented to the government in 1984. [FN285] A study completed in 1992 by the New York State Advisory Committee to the U.S. Commission on Civil Rights showed that these *470 same problems persisted. [FN286] The federal government is also guilty of failing to enforce Title VI to prevent racial discrimination in health care. The U.S. Commission on Civil Rights reviewed the progress of federal agencies

enforcement of Title VI in 1974 and 1996. Each time the U.S. Commission on Civil Rights found that the federal agencies, such as HHS, responsible for enforcing Title VI were not fulfilling the mandates of the Act. [FN287] This has left African Americans with no regulatory avenue to put an end to this discrimination. Notwithstanding federal agencies' failure to enforce Title VI, the Supreme Court has barred private parties from disparate impact claims under Title VI. [FN288] The lack of Title VI enforcement by HHS and the Supreme Court's ruling barring private parties from bringing disparate impact Title VI claims has left elderly African Americans subject to racial discrimination without any means to rectify the problem.

V. De Facto Segregation and Disparate Impact: The Promise of a Dream Denied

The United States promised to eradicate racial discrimination against African Americans in all facets of public life with the passage of the Civil Rights Act of 1964. [FN289] In particular, the enactment of Title VI was significant because it “mandate[d] the exercise of existing authority to eliminate discrimination by Federal fund recipients and would furnish the procedure to support this purpose.” [FN290] The purpose of Title VI was to put an end to all “discriminatory activities, including denial of services; differences in quality, quantity, or manner of services.” [FN291] Through both inactivity and intentional actions, the United States has reneged on its promise to prevent racial discrimination in health care.

Section 602 of Title VI provides that the United States government prevent racial discrimination that denies African Americans access to quality health care. [FN292] If the government delegates this responsibility to the states, then the “[f]ederal agencies must evaluate the quality of Title VI efforts conducted by State recipients and provide assistance whenever necessary” to comply *471 with the mandates of section 602. [FN293] To date, the government has failed to put an end to racial discrimination in health care and to monitor the efforts of the states, allowing the continuation of racial discrimination by federally funded health care entities, in violation of Title VI. [FN294] Illustrative of the continuation of racial discrimination is the failure of African Americans to be admitted to and provided quality care by nursing homes funded by the federal government.

By underfunding civil rights enforcement, the federal government has failed to address this racial discrimination in the provision of nursing home care. With the absence of government enforcement by HHS, an agency of the executive branch, elderly African Americans were left to bring cases against nursing homes that racially discriminate. Since 1964, nursing homes have removed most forms of disparate treatment racial discrimination, but disparate impact racial discrimination remains. [FN295] Even with two decades of empirical data and government reports showing the prevalence of discrimination as a result of disparate impact and the failure of the government to rectify this discrimination, [FN296] the Supreme Court barred a private right of action challenging disparate impact discrimination based on “a flawed and unconvincing analysis of the relationship between sections 601 and 602 of the Civil Rights Act of 1964, ignoring more plausible and persuasive explanations detailed in [the Supreme Court's] prior opinions.” [FN297]

A. Government Inactivity

Since the passage of the Civil Rights Act of 1964, scholars have noted the failure of HHS to prevent and eradicate racial discrimination in health care as mandated by Title VI of the Civil Rights Act of 1964. Critics have noted that HHS “permitted formal assurances of compliance to substitute for verified changes in behavior, failed to collect comprehensive data or conduct affirmative compliance reviews, relied too heavily on complaints by victims of discrimination, inadequately investigated matters brought to the Department, and failed to sanction recipients for demonstrated *472 violations.” [FN298] The creation of OCR in 1967 did little to address

the critics' comments because HHS has underfunded and understaffed OCR. [FN299] For example, HHS has a financial assistance budget of \$225 billion, eight times that of the U.S. Department of Education (“DOE”), but HHS devotes only \$22.2 million for its civil rights budget, one half of the civil rights budget of the DOE. [FN300] The civil rights staff of HHS is one-third as large as that of the DOE. [FN301] From 1981 to 1993, OCR's staff declined from 524 to 309, while the OCR staff specifically responsible for Title VI enforcement decreased from 246 to 108. [FN302]

Hampered by underfunding and understaffing, OCR, the division of HHS responsible for Title VI enforcement in health care, has systematically failed to address racial discrimination in health care as prescribed by Title VI. [FN303] OCR has failed to conduct adequate preaward reviews, investigate private complaints, or collect information necessary to determine whether nursing homes are continuing to racially discriminate. These failures have been due both to changes in executive branch policy and a lack of commitment by OCR to fulfill the dictates of Title VI.

For instance, in 1968, the Secretary of HHS separated OCR's enforcement of Title VI from the authorization of federal funding and regulation of nursing homes. [FN304] This authority to regulate nursing homes participating in programs such as Medicare was delegated to the Centers of Medicare and Medicaid Services (“CMS”), [FN305] a division of HHS, and the authority to regulate nursing homes under Medicaid was delegated to the states. This shift meant that OCR had no authority to review Title VI compliance of nursing homes regulated *473 by CMS or by the states. [FN306] OCR's only responsibility became completing a review of nursing homes before they were certified to participate in Medicare, a preaward review. [FN307] Notwithstanding its limited role in award reviews, OCR has not always been fastidious in reviewing nursing home compliance with Title VI. Even though OCR's internal procedures for complying with Title VI requirements called for detailed review of new nursing home applicants, over a twelve-year span, from 1981 to 1993, most of OCR's reviews were cursory desk-audits. [FN308] These desk-audits included a review of preaward assurances of nondiscrimination by nursing homes, but according to the U.S. Commission on Civil Rights, the information provided was not sufficient to determine actual Title VI compliance. [FN309] Hence, beneficiaries could suffer discrimination before HHS could identify it at the postaward stage. [FN310]

All postaward review of Medicare certified facilities was delegated to CMS, which has done little to enforce the requirements of Title VI. [FN311] All Title VI compliance reviews of Medicare nursing homes were delegated to the states in 1980. [FN312] The states' duties included reviewing private complaints and spot-checking reviews of compliance documents. [FN313] According to the U.S. Commission on Civil Rights, “HHS has not implemented a systematic process to review States' Title VI compliance activities on a regular basis.” [FN314] Instead, HHS has delegated some minimal responsibilities to OCR. Under Medicare, OCR has remained responsible for handling private complaints received by the state and reviewing the states' findings. [FN315] OCR's only Title VI compliance review of Medicare certified nursing homes has been in response to private complaints, [FN316] and according to *474 the United States House of Representatives, OCR failed to even complete this task. [FN317]

A 1987 report from the United States House of Representatives Committee on Government Operations found “that OCR unnecessarily delayed case processing, allowed discrimination to continue without federal intervention, routinely conducted superficial and inadequate investigations, failed to advise regional offices on policy and procedure for resolving cases, and abdicated its responsibility to ensure that HHS policies are consistent with civil rights law, among other things.” [FN318] Furthermore, the Committee on Government Operations “criticized OCR's reluctance to sanction noncompliant recipients and recommended that OCR pursue investigations of complaints as well as compliance reviews in more systematic ways.” [FN319] The failure to resolve

cases to ensure that nursing homes do not continue to racially discriminate violates the spirit of the requirements of section 602 of Title VI, which mandates OCR to take steps to remediate racial discrimination by nursing homes. [FN320]

Since the House of Representatives committee report regarding the problems of OCR, OCR has not made a good faith effort to fulfill its statutory duties. [FN321] In the 1990s, when OCR received complaints from private parties, it still failed to fulfill its Title VI mandate of combating racial discrimination. [FN322] For instance, in 1993, ten of the twenty-one complaints filed resulted in findings of noncompliance with the requirements of Title VI. [FN323] Every complaint was resolved through voluntary commitments to cease and desist discriminatory practices. [FN324] No cases were referred to the U.S. Department of Justice, nor did HHS initiate any administrative proceedings. [FN325] Thus, the perpetrators of racial discrimination were given a slap on *475 the hand, while the victims of the discrimination who suffered harm were left with no relief.

In addition to handling complaints, OCR's internal policies to fulfill the dictates of Title VI require OCR to collect and review nursing home data, such as the number of beds and racial and ethnic data on patient admissions. [FN326] OCR has not fulfilled this mandate of Title VI. [FN327] In 1994, HHS decreed that it would not collect racial and ethnic data regarding services provided in nursing homes receiving federal funding. [FN328] OCR does not review any racial data of residents from the states [FN329] or collect any report on services provided, so there is no opportunity to evaluate whether racial groups are treated disparately. [FN330] Without the collection of racial and ethnic data, there are no means by which OCR can evaluate whether nursing homes are "using criteria or methods of [administration] which [have] the effect of subjecting individuals to discrimination" because of their race. [FN331] Now that nursing homes have implemented "facially neutral" practices that have a disparate impact on African Americans, it is impossible for OCR to evaluate these discriminatory practices without collection or review of this data. [FN332] For instance, although a nursing home may decide not to admit a patient because he or she is African American, it is difficult to ascertain this practice of racial discrimination because OCR does not collect any data concerning those who apply for admission, and thus there are no statistics indicating who is admitted versus who is denied. [FN333]

As a defense to its failure to enforce Title VI, OCR may assert that, since its creation, the executive branch has failed to make addressing racial discrimination in health care a priority. For instance, until the Department of Education was created in 1979, most of OCR's Title VI efforts were devoted to education desegregation, while "only 4 percent of OCR's compliance efforts were *476 devoted to health and social services." [FN334] OCR spent the next twenty-seven years litigating cases concerning interracial adoption and the implementation and regulation of the Health Insurance Portability and Accountability Act. [FN335] However, this is not an excuse, because section 602 of Title VI mandates that OCR to take steps to prevent racial discrimination by government-funded health care entities. [FN336] Nevertheless, OCR has focused on non-life-threatening issues leading to the proliferation of racial inequities in health care due to racial discrimination, which continue to seriously compromise the health of elderly African Americans across the nation. OCR does not collect nor review racial data from the states to determine whether nursing homes are discriminating against African Americans. [FN337] Moreover, when OCR receives private complaints concerning the racially discriminatory practices of nursing homes, it does not impose remedies. [FN338] It merely accepts the offending nursing home's promise that the behavior will be corrected. [FN339] The failure of OCR to remediate racial segregation and discrimination in health care, particularly in nursing home admissions and the provision of quality care, represents a failure to enforce Title VI. Private parties have tried to put an end to the discrimination by filing civil cases against nursing home violators, but the courts have barred these suits claiming that the authority to rectify the problems remains with the same government agencies notorious for not enforcing Title VI. [FN340] The Supreme Court's actions have negated African Americans' right to equal access to government-funded services. [FN341]

B. The Evisceration of Title VI

No longer do nursing homes advertise or admit that their facilities are “white only.” Instead, a plethora of research studies show that some nursing homes simply deny admission and quality care to African Americans based on race, using “neutral policies” *477 such as cultural differences, geographical racial segregation, and socioeconomic status. [FN342] Consequently, private parties now use Title VI to combat racial discrimination through disparate impact. [FN343]

In the 1970s and 1980s, elderly African Americans brought lawsuits in *Linton ex rel. Arnold v. Commissioner of Health & Environment* [FN344] and *Taylor v. White* [FN345] against the government, regarding nursing homes' use of Medicaid to discriminate against African Americans. The plaintiffs in these lawsuits asserted that the states' policies for Medicaid bed certification allowed nursing homes to racially discriminate. [FN346] Some nursing homes would deny African American Medicaid patients admission because the nursing home did not have any Medicaid beds, but if a White Medicaid patient sought admission, then another Medicaid bed would be certified. [FN347] Thus, nursing homes used Medicaid as a proxy to deny African Americans admission based on neutral policies, in violation of Title VI. [FN348] Serving as an example for subsequent Title VI cases, the plaintiffs in *Linton* and *Taylor* asserted successful claims using the theory of disparate impact discrimination to show that the states' policies were supporting the racially discriminatory practices of the nursing home industry. The Supreme Court put an end to these suits when it decisively ended private parties' right to challenge disparate impact cases in *Alexander v. Sandoval*. [FN349]

In *Sandoval*, a non-English-speaking American, *Sandoval*, filed a federal case challenging the failure of the Alabama Department of Public Safety (“Department”) to provide driver's license exams in languages other than English. [FN350] *Sandoval* asserted that the use of English-only exams excluded people on the basis of race, color, and national origin from obtaining a driver's license. [FN351] Section 601 of Title VI prohibits discrimination based on race, color, and national origin that prevent individuals from participating in any program *478 receiving federal funding. [FN352] Because the Department received federal funding from the U.S. Department of Justice, *Sandoval* alleged that exclusion of people based on race, color, and national origin was a violation of Title VI. [FN353] The Department argued that its actions did not violate Title VI because the discrimination was not intentional. The discrimination resulted from a provision of the Alabama Constitution that English was the official language of Alabama and, thus, the discrimination was a result of disparate impact of “neutral policies.” [FN354] The Supreme Court reviewed the case solely for the purpose of determining whether private parties had a right to sue under Title VI for discrimination as a result of disparate impact. [FN355]

The Supreme Court ruled that private parties do not have a right to sue for disparate impact discrimination. [FN356] The Court reasoned that, because the language of section 601 of Title VI only grants a private right of action for intentional discrimination, regulations that prohibit disparate impact do not apply because section 601 permits disparate impact. [FN357] The Court found that disparate impact cases could only be addressed under section 602 of Title VI, because the only prohibition against disparate impact discrimination is found in the regulations referring to section 602. [FN358] Supreme Court precedent dictates that there is no private right of action because a private plaintiff cannot bring a suit based on regulations for acts not prohibited by the statute. Thus, the Supreme Court ruled that the Title VI regulations do not provide a private right of action for disparate impact, because private parties do not have a private right of action under Title VI to sue for disparate impact. [FN359]

The Court made this decision even though, when the statutory language of Title VI was passed in 1964, the artificial court-created distinction between good and bad racial discrimination, i.e., disparate impact versus disparate treatment, had not been announced. [FN360] This *479 distinction was not created until 1971. [FN361]

Congress has not revised the language of Title VI since 1964, yet the courts have continued to change their perception of what the language means. [FN362] Justice Stevens notes in his dissent that for thirty years after the Supreme Court devised this distinction between disparate treatment and disparate impact, private plaintiffs had a private right of action to challenge disparate impact discrimination under Title VI. [FN363] The majority negated this precedent, by barring victims' access to the courts. [FN364] Moreover, the majority's decision to bar private parties' access to the federal courts under Title VI is contrary to the intent of Congress. [FN365] When enacting Title VI, members of Congress specifically discussed the *Simpkins* case, a private case challenging racial discrimination, using it as an example of the rights granted under Title VI. [FN366] Because Congress enacted Title VI before the distinction between disparate treatment and disparate impact, the legislature did not address whether the distinction affects private rights of action. [FN367] Notwithstanding this fact, Congress noted the import of private rights of action to enforce Title VI separate from the government's authority to enforce Title VI. [FN368]

Due to the majority's opinion in *Alexander v. Sandoval*, [FN369] African Americans have been forced once again to take the matter in their own hands. [FN370] By barring African Americans from obtaining judicial review and negating all agency review under Title VI through underfunding and understaffing, the United States has left African Americans with little hope to rectify racial discrimination under Title VI. Therefore, elderly African Americans and their advocates must seek innovative solutions to address the continuation of racial discrimination in health care, such as the Medicaid Act, the Fair Housing Act, and CERD, to force the government to take steps to end racial discrimination in health care.

*480 VI. Solutions

Two decades of empirical studies [FN371] and government reports [FN372] suggest that the best predictor of admission to a quality nursing home is race, regardless of the geographic location, type of nursing home (religious, not for profit, for profit), or payment source of the resident. The failure of OCR, charged with enforcing Title VI, to prevent racial discrimination and segregation in health care, has left vulnerable elderly African Americans to be relegated to substandard nursing homes. Even when brought to the attention of nursing home administrators, state regulators, and federal regulators, there has been no change. [FN373] The most direct ways to rectify this problem would be using the political system or filing a lawsuit against the government for abdicating its legal responsibility to prevent racial discrimination under Title VI. However, neither avenue seems promising in the current political climate.

Regardless of the political party in the executive or legislative branch since 1964, little has been done to address racial discrimination in long-term care. [FN374] As discussed above, numerous government reports show that HHS, an Executive Branch agency, has routinely failed to effectively enforce Title VI. [FN375] These reports have been presented to Congress, which has done little to induce HHS to improve its Title VI enforcement efforts. In light of this political reality of inactivity in Title VI enforcement, the only redress available to racial discrimination victims has been through the *481 courts. In spite of this, the federal courts have seemingly closed this avenue.

In *Madison-Hughes v. Shalala*, [FN376] patients sued the Secretary of HHS for failing to enforce section 602 of Title VI. Specifically, the patients challenged the Secretary's failure to collect racial data and information needed to prove the continuation of racial discrimination in health care. [FN377] The Court of Appeals for the Sixth Circuit ruled that this duty was discretionary, because the only duty of HHS was to obtain Title VI compliance reports from health care entities with as much information as necessary. [FN378] According to the court, the extent to which HHS monitored and enforced Title VI was under the discretion of HHS. [FN379] Therefore,

although the language of Title VI says that the federal government must enforce Title VI, it does not say how. [FN380] The “how” is in the discretion of the Secretary. [FN381] Based on Madison-Hughes, as long as the government is investigating complaints and seeking voluntary compliance, it is enforcing Title VI. This is the case even though reports from the House of Representatives and the U.S. Commission on Civil Rights note that racial discrimination continues almost unfettered, as it did before the passage of Title VI. [FN382] The court's decision in Madison-Hughes has cast significant doubt on the success of actions directly challenging the government's failure to enforce Title VI. Nevertheless, elderly African Americans and their advocates cannot give up the fight.

To solve this continuing problem of racial discrimination in nursing homes, African Americans have several options, including using the Medicaid Act, the Fair Housing Act, and CERD to induce the federal government to actively and effectively enforce Title VI. The least controversial claim is under Medicaid. Elderly African Americans could sue the United States in federal court for failing to provide quality nursing home care, as required by the Medicaid *482 Act. [FN383] This approach was successfully used by Medicaid recipients in Colorado to induce the federal government to improve access to quality care in nursing homes under Medicaid. [FN384] Elderly African Americans can also file complaints with the U.S. Department of Housing and Urban Development (“HUD”) for housing discrimination. Elderly African Americans can employ HUD to send out racially different testers to nursing homes to request admission, and compile this data to support an intentional discrimination lawsuit under the Fair Housing Act against nursing homes that racially discriminate. [FN385] Finally, elderly African Americans could use international law to pressure the United States to prevent the continuation of racial discrimination in nursing homes by filing a complaint under CERD. [FN386] Full analysis of each solution, including the strengths and weaknesses, will be discussed in future articles, but a brief discussion of each solution follows.

A. The Medicaid Act

As discussed in Section V.B, elderly African Americans have used the Medicaid Act in concert with Title VI to challenge the failure of nursing homes to provide equal access. [FN387] The availability *483 of these claims has been called into question because of the Supreme Court's decision to bar private rights of action for disparate impact claims under Title VI. Nevertheless, elderly African Americans can still use the Medicaid Act to pressure state and federal governments to enforce Title VI.

Under the Medicaid Act, the federal and state governments are required to regulate the actual care provided to residents. [FN388] If the care does not comply with the Medicaid Act, then the federal and state governments are required to discipline the nursing home. As discussed above, empirical studies show that many elderly African American Medicaid patients are not provided quality health care and the nursing homes are not sufficiently disciplined for not providing quality care. [FN389] Thus, the federal and state governments are failing to fulfill their duties under the Medicaid Act to require nursing homes to provide quality care to African American Medicaid recipients. Because the federal and state governments are not effectively disciplining substandard nursing homes and are allowing substandard nursing homes to remain in government-funded programs, the government is in violation of the Medicaid Act. Thus, elderly African American residents should file a claim against the government for violating Medicaid. Such an action would be sustainable if reviewing courts were to follow the holding of *Estate of Smith v. Heckler*. [FN390]

In *Heckler*, Colorado residents living in Colorado nursing homes brought a class action civil rights suit against the Secretary of Health and Human Services. [FN391] The Medicaid recipients asserted that the *484 Secretary violated their constitutional right to receive quality medical and psychosocial care in nursing homes by

failing to fulfill his statutory duty under Medicaid to regulate the actual care provided in nursing homes. [FN392] The Secretary argued that HHS had fulfilled the requirements of Medicaid by publishing advisory enforcement standards that govern state inspection of Medicaid certified nursing homes. [FN393] The arguments of both the plaintiff and defendant centered on the duties of the Secretary under the Medicaid Act to regulate nursing homes' care. [FN394]

The Medicaid Act authorizes the Secretary to fund state plans to provide “health care to needy persons” through agreements with private and public persons and institutions capable of providing such services. [FN395] Under § 1396(a) of the Social Security Act, the Secretary could only approve state plans that included the condition that the plan provide a description of the methods of inspection the state would use to certify that the nursing homes provided high quality care. [FN396] The Secretary had the authority to “look behind” the state's determination of a nursing home's compliance with the state Medicaid plan. [FN397] Based on the “look behind” provision, if the Secretary found that the state plan was deficient and the state failed to show that it had implemented an effective inspection program, the Secretary had to reduce the percentage of federal funds given to the state's Medicaid program. [FN398]

The United States Court of Appeals for the Tenth Circuit ruled that the Secretary had violated the plaintiffs' constitutional rights by failing to regulate the actual care of patients. [FN399] The court reasoned that the federal forms, which the states were required to use to evaluate the facilities, failed to ensure patients received quality care and thus violated the dictates of the Medicaid Act because the purpose of the Act was to provide high quality medical care to needy *485 persons. [FN400] The court reviewed the legislative history of the “look behind” provision and found that Congress passed the law “to assure that Federal matching funds are being used to reimburse only those [skilled nursing facilities] . . . that actually comply with [M]edicaid requirements.” [FN401] Consequently, the court ruled that, by granting the Secretary the “look behind” authority, Congress mandated that the Secretary, when the Secretary had cause, make an independent determination of whether a Medicaid certified nursing home actually meets the requirements of the state plan, irrespective of the state's findings. [FN402] According to Congress, cause included complaints made to the Secretary by the residents, advocates, or others about the quality of care or condition of the facility. [FN403] Because the residents in this case had complained to the Secretary about the quality of care, and the Secretary failed to use his authority under the “look behind” provision, the court remanded the case back to the district court and ordered the district court to compel the Secretary to revise and implement new Medicaid regulations that focused on the quality of care furnished to Medicaid recipients in nursing homes. [FN404]

This decision by the court of appeals [FN405] not only affected Medicaid regulations, but it also influenced the regulation of Medicare certified nursing homes because the enforcement system HHS advised the states to use in regulating Medicaid certified facilities was the same system HHS used in regulating Medicare certified facilities. [FN406] Hence, the decision also called into question the *486 validity of the Medicare regulations. This class action lawsuit, coupled with the findings of an independent federal government report on poor nursing home quality, was the catalyst for significant congressional changes in the way that nursing homes were regulated under Medicaid and Medicare. [FN407] Just as these Medicaid recipients challenged the enforcement of quality of care regulations by the Secretary, so should elderly African Americans.

Data shows that elderly African Americans are subject to poor quality care regardless of whether they are residing in nursing homes with Whites or not. [FN408] Professor Fennell has noted that “it is possible for a nursing home to provide, on average, high quality of care and to also exhibit a substantial disparity on the levels of care received by majority and minority residents.” [FN409] A study of several states, including New York, Kansas, Mississippi, and Ohio, found that when Whites and African Americans reside in the same facility, the

quality of care provided is different. [FN410] In addition to these racial inequities in care when residing in the same facility, there are significant inequities when the races reside in different nursing homes. [FN411] According to national data compiled from Medicare forms, African Americans reside in nursing homes with “lower ratings of cleanliness/maintenance and lighting.” [FN412] Because it has been consistently demonstrated for the last two decades that elderly African Americans experience poor quality nursing home care, elderly African Americans should file a suit against the Secretary of HHS for failing to provide quality care as required by the Medicaid regulations. As in the Heckler case, [FN413] the Secretary has cause to “look behind” the caregiving of the nursing homes, because many Title VI complaints and research studies have noted the poor quality of nursing homes based on race. Neither the Secretary nor HHS has increased the discipline of these nursing homes, which provide substandard quality of care to African Americans, or decreased Medicaid payments to states that fail to adequately discipline these nursing homes. Therefore, to obtain a lasting change, elderly African Americans and their advocates should file an injunctive and declaratory claim seeking the fulfillment of the promise of quality in nursing home care.

*487 Filing a case such as this one can be timely and costly. However, this may be the best option to induce the federal government to improve the quality of nursing homes. The courts may question whether the Secretary's actions are enough to obtain quality nursing home care, and thus it is within the discretion of the Secretary on how to provide quality services. However, because there is enough empirical data to show that the nursing homes in which African Americans reside are of substandard quality, it really is not a matter of methodology, but a matter of attainment of quality care. Furthermore, based on the history of Linton [FN414] and Taylor, [FN415] plaintiff Medicaid cases have been successful in getting the state and federal government to change their regulatory behavior. This option will not improve the quality of care provided to private pay elderly African Americans residing in nursing homes not participating in the Medicare or Medicaid programs. However, it will provide assistance to some of the most vulnerable elderly, indigent African Americans. Another option for increasing government involvement in the continued fight against racial discrimination in nursing homes is to file claims under the Fair Housing Act for housing discrimination. [FN416]

B. The Fair Housing Act

During the passage of Title VI, Congress noted that, unlike hospitals, nursing homes were more than simple treatment centers. [FN417] Nursing homes were viewed as private residences funded by the government. [FN418] In the 1960s, Congress was unwilling to wage a massive attack to integrate these “homes,” [FN419] but elderly African Americans can now use this to their advantage. Because nursing homes are considered “homes,” it is clear that the use of race to prohibit admission to these government-sponsored homes constitutes a violation of the Fair Housing Act. [FN420] Under the Fair Housing Act, those providing housing are prohibited from denying rental of a dwelling because of race. [FN421] In fact, section 3604(a) prohibits refusals to deal and avoidance techniques used to deny housing to racial *488 minorities, even if a definite rejection is not given. [FN422] One well-recognized avoidance technique is informing racial minorities that housing does not exist, while telling Whites that there are units available. [FN423] To establish a prima facie case under the Fair Housing Act, one needs to prove: (1) that the victim “is a member of a racial minority”; (2) that the victim “applied for and was qualified to rent” “certain property or housing”; (3) that the victim was rejected; “and (4) [t]hat the housing or rental property remained available thereafter.” [FN424] Under section 3612 of the Fair Housing Act, the federal government has the authority to prevent racial discrimination in housing in violation of section 3604(a). [FN425]

Like OCR in health care, HUD is required to investigate private complaints of racial discrimination in housing. [FN426] If HUD finds that the complaint is valid, it can institute an administrative action against the perpet-

rator, and if the party is found to have violated the Fair Housing Act, then a civil penalty in the amount of \$10,000 to \$50,000 can be assessed. [FN427] Like the administrative process of OCR, *489 the HUD process has been noted for its delays and failures to adequately resolve cases in which guilty determinations have been made. Nevertheless, unlike OCR, HUD has actually initiated administrative complaints against perpetrators. [FN428] The better government avenue is to get the U.S. Attorney General to file a civil claim in district court to resolve the matter. Although it is within the sole discretion of the U.S. Attorney General to file cases, there has already been one nursing home case under the Fair Housing Act concerning racial discrimination. [FN429]

In the early 1990s, the federal government filed an action against Lorantffy Care Center (“Lorantffy”), a nursing home, for housing discrimination based on its alleged racially discriminatory admission practices. [FN430] The government used the Fair Housing Act to show that the nursing home had racially discriminated against African Americans seeking admission to the nursing home. [FN431] The government asserted that Lorantffy had violated section 3604 of the Fair Housing Act, because it used avoidance techniques to deny admission to African Americans when the nursing home had beds available. [FN432] The director of the local fair housing agency used a series of fair housing tests to determine if the nursing home discouraged African Americans from applying for admission. [FN433]

In each of the four tests, the testers were instructed to inquire about availability of admitting an elderly relative to the nursing home on short notice. [FN434] The tests were structured to match a Black tester and a White tester as closely as possible in all relevant traits, such as medical condition and method of payment. [FN435] Based on the tester evidence, the United States asserted that the admission staff of the nursing home, the social worker, and executive director did not make the same effort to adequately guide Black testers through the process of qualifying for a nursing home as they did for the White testers, violating section 3604 of the Fair Housing Act. [FN436]

*490 The nursing home asserted several defenses for its different treatment of the White and Black testers. [FN437] First, Lorantffy explained that each tester conducted him or herself in a different manner, and thus received varying responses from the admission staff of Lorantffy. [FN438] Second, Lorantffy was specifically established to provide a nursing home for older Hungarians with an Eastern/Hungarian atmosphere, so they provided Hungarian and Eastern European food, furnishings, art, literature, and entertainment. [FN439] The implication of that assertion is that the admission decisions were based on cultural differences and not racial differences. Third, Lorantffy submitted that it rarely admitted “walk-in” applicants, as occurred in the testing, but rather most of Lorantffy’s residents were referred by hospitals. [FN440] Finally, Lorantffy argued that the United States used the same structure to test Lorantffy that it has traditionally used to test apartments, despite nursing homes presenting far more complex situations. [FN441] For example, the nursing home must determine if it can meet the medical needs of a patient. [FN442] The jury found the nursing home not guilty of violating the Fair Housing Act. [FN443]

Although the government lost this initial case, it does not mean the government cannot use the Fair Housing Act to rectify racial discrimination in health care. It simply means that some changes need to be made in the strategy and evidence presented. First, all the testers need to fill out an application to reside in the nursing home. Second, the prospective residents should be prescreened and approved for admission to a nursing home by the appropriate state office. Third, the testers should provide screeners with physician-approved documents for admission. Fourth, the government should also use a physician or hospital discharge staff to call on behalf of the testers and seek admission for African American and White patients. Finally, the government needs to use the empirical data on racial discrimination and a nursing home expert to address how racial *491 discrimination is used by the nursing home industry to prevent the admission of African Americans to quality nursing homes. By

implementing these changes, a lawsuit based on the Fair Housing Act is more likely to be successful.

Using the housing discrimination framework definitely has its weaknesses, for like the Title VI framework in HHS, HUD's administrative prosecution of alleged perpetrators has not been stellar. Furthermore, it is in the sole discretion of the U.S. Attorney General to take a case to federal court. Thus, as under Title VI, private parties are subject to the whims of the federal government when it comes to enforcement of the Fair Housing Act. Researchers have also discussed at length the fact that African Americans remain in geographical racial segregation because of racial discrimination, preventing them from moving into White neighborhoods in spite of the Fair Housing Act's prohibition against racial discrimination. [FN444] However, by using this system, legal advocates would be able to continue to fight against racial discrimination in health care in court rather than just through regulatory actions, and could reap the rewards of civil penalties and monetary damages missing under Title VI. If these domestic options fail, elderly African Americans and their advocates should take the fight to the international community.

International attention garnered from the Civil Rights movement may have forced the federal government to initiate steps to end de jure segregation, [FN445] which trickled down to health care entities and nursing homes. Although the international pressures of trying to stop the spread of communism are no longer present, using domestic and international measures to publicize the problem can force the government to become more active in the fight against racial discrimination.

*492 C. The International Convention on the Elimination of All Forms of Racial Discrimination

The International Convention on the Elimination of All Forms of Racial Discrimination ("CERD") prohibits the United States from funding racial discrimination. [FN446] The CERD directs member states, such as the United States, to "condemn racial discrimination and undertake to pursue by all appropriate means . . . a policy of eliminating racial discrimination in all its forms." [FN447] Member states are in violation of the CERD when they fail to implement measures to eradicate intentional and unintentional forms of racial discrimination. [FN448] Private parties have the right to file a complaint concerning a member state's violation of the CERD with the Committee on the Elimination of Racial Discrimination ("the Committee") when there is no meaningful way to address the issue domestically. [FN449] Once a complaint is found valid, not only does the member state have to change its policies and procedures, but also there is a right to seek reparations for damages suffered. [FN450] Although it took twenty-eight years for the United States to ratify the CERD, it is now in force. [FN451]

Under the CERD, the United States is required to put an end to all discrimination committed by public institutions. [FN452] The broad goals of the CERD are to be implemented to protect the enjoyment of *493 several rights, such as equal access to health care. [FN453] Comparable to the mandates of the CERD, Title VI prohibits racial discrimination by public institutions that are funded and the subject of government regulation. [FN454] Moreover, Title VI and the CERD both govern individuals' right to enjoy numerous fundamental freedoms on equal footing, such as the right to education and health care. [FN455] The United States has violated the CERD by failing to enforce Title VI and continuing to fund nursing homes that commit racial discrimination.

Specifically, the United States, a member state, is not complying with the requirements of the CERD because nursing homes that receive federal funding continue to discriminate against African Americans without any action by the government. HHS has failed to enforce Title VI, thereby relegating elderly African Americans to substandard nursing home care. Since the passage of the Civil Rights Act of 1964, critics have noted the failure of HHS to prevent and eradicate racial discrimination in health care as mandated by section 602 of Title VI

of the Civil Rights Act of 1964. [FN456] The effects of racial discrimination on the well-being of elderly African Americans is evidenced by their failure to access quality health care regardless of their gender, education, health insurance, or socioeconomic status. [FN457]

Decades' worth of research studies show that African Americans are systematically denied access to quality nursing homes. [FN458] This evidence has been submitted to OCR in the form of research findings [FN459] and in the form of complaints against the perpetrating nursing homes. [FN460] Nevertheless, the federal government continues to fund these facilities. [FN461] Thus, the burden of enforcing Title VI to *494 combat racial discrimination in health care has been placed on private parties. [FN462] However, the Supreme Court decisively ended private parties' right to challenge these cases when it decided *Alexander v. Sandoval*, [FN463] leaving private parties who have been discriminated by health care institutions with no other avenue of redress. [FN464]

Because there are few domestic means to address the continuation of implicit government-sanctioned racial discrimination and segregation in nursing homes, elderly African Americans should file a complaint with the Committee, for the United States' violation of the CERD. The only drawback is that the findings of the Committee are not binding, but this is better than the voluntary compliance sought by OCR that never materializes. Furthermore, a binding decision can be obtained by filing a claim with the International Court of Justice, with the consent of the United States. To date the United States has not consented to or recognized the authority of the International Court of Justice to resolve complaints. Thus, the most one could hope for is that the United States will voluntarily comply in enforcing Title VI. Notwithstanding this less-than-perfect outcome from international law, elderly African Americans can put pressure on the United States government by bringing both domestic and international action. This dual litigation strategy would put pressure on the United States both in court and in the public forum. Furthermore, if the Medicaid and Fair Housing cases were not successful, it would serve as further support for the international action, demonstrating that there are no further domestic avenues available to elderly African Americans to end racial discrimination in health care. Filing these actions simultaneously in federal court and with the Committee may be the pressure needed to galvanize the government into enforcing Title VI.

It is the responsibility of government to prevent racial discrimination. However, the government has failed to take care of its legal responsibility. Therefore, private parties must use the lessons from the civil rights movement and file claims and complaints against the perpetrators to put an end to racial discrimination in health care. By using current domestic and international law in innovative means, elderly African Americans can induce the government to fulfill its forty-two-year promise of equality in health care. The benefit of using the Medicaid Act, the Fair Housing Act, and CERD is that the relief requires the issuance *495 of an order against the government or the perpetrators of racial discrimination. In the past, orders have required the government to adopt new standards by which to fulfill the requirements of these laws. [FN465] If the government or the perpetrators of racial discrimination do not comply with these standards, the plaintiffs have the authority to go back to court or to the Committee to seek compliance with the order. Each action has its own weakness, which will be fully discussed in future articles. Nevertheless, it is clear that filing these claims will be better than current options available to many elderly African Americans, who are disproportionately suffering from a lack of access to quality health care.

VII. Conclusion

African Americans have been struggling for equality for almost five hundred years. Illustrative of the never-ending struggles of African Americans to obtain equality is the failure of African Americans to access quality health care regardless of their gender, education, or socioeconomic status. The United States health care system has been plagued by racial discrimination since its creation, resulting in significant failures in providing quality

care to minority populations. Decades of empirical data and government reports show that elderly African Americans have a higher mortality rate, morbidity (disability) rate, and less access to health care. The federal government intervened on behalf of African Americans to rectify this injustice of racial inequality in health care by enacting Title VI, but seemingly became content in funding studies showing the existence of racial discrimination in nursing homes, and its sponsorship of these nursing homes that racially discriminate. This sponsorship entails funding of nursing homes that racially discriminate, underfunding the agency responsible for combating discrimination in nursing homes, and barring private parties from suing to prevent the discrimination allowed by the government. The literature establishes that some nursing homes continue to racially discriminate by delaying elderly African Americans access to quality nursing home care. Nursing homes delay transfer and deny admission of elderly African Americans to quality facilities based solely on the criterion of race. Such discriminatory practices on the basis of race continue in clear contravention of Title VI, the federal statute passed forty-two years ago that prohibits racial discrimination by health facilities that receive federal funding.

The failure of OCR, charged with enforcing Title VI, to prevent racial discrimination and segregation, has caused elderly African Americans to be relegated to substandard nursing homes. Even when *496 brought to the attention of nursing home administrators and state and federal regulators there has been no change. [FN466] Given the regulation and enforcement mechanisms established under Title VI explicitly aimed at remedying racial discrimination, such as that directed at elderly African Americans, it is unbelievable that these practices continue. Thus, one must ask whether the protections offered by Title VI are more illusory than real in the health care industry. Based on a review of the empirical data and governmental action in this area, the answer seems to be that Title VI offers little more protection against racial discrimination than a broken umbrella during a hurricane.

To solve this problem, elderly African Americans and their advocates must seek innovative methods to put an end to racial discrimination in health care. This paper proposes a three-faceted option using the Medicaid Act, the Fair Housing Act, and CERD. By using these solutions, elderly African Americans and their advocates can build on the success of earlier Medicaid quality and Fair Housing Act cases, and put international pressures on the United States to address its embarrassing unsolved racial problems. Whether used separately or used in concert, these solutions provide a way to induce the government to make African Americans' dream of equality a reality.

[FN1]. Assistant Professor, Loyola University Chicago School of Law. B.A. (Honors Biology), University of Michigan, 1996; J.D., Georgetown University Law Center, 2000; M.P.H., Johns Hopkins School of Public Health, 2000. A version of this paper was presented at the American Association of Law Teachers Conference, the American Society of Law, Medicine & Ethics Teachers Conference, and the American Public Health Association Conference. This article was made possible by a research grant from Loyola University Chicago. I would like to thank Sacha Coupet, Michele Goodwin, Christine Jones, Ayana Karanja, and Neil Williams for their assistance and support. Additionally, I would like to thank my outstanding research assistants, Damon Doucet, Dan Spira, Nakeyia Williams, and Ketura Baptise. I dedicate this work to my mother, Ayanna Yearby, my grandmother, Irene F. Robinson, my aunt, Askousa Ventour, and my husband, Roderick Nelson.

[FN1]. This is a true story. Ms. Morgan and Ms. Popowich were government testers sent to the facility in response to complaints concerning racial discrimination in the denial of admission to the facility. The only change to the story is the omission of the name of the facility and employees. See Trial Brief of the United States at 4-6, [United States v. Lorantffy Care Ctr.](#), 999 F. Supp. 1037 (N.D. Ohio 1998) (No. 97-CV-00295). This case was filed by the federal government against a nursing home for violating the Fair Housing Act based on evidence of

racial discrimination.

[FN2]. See Trial Brief of [Lorantffy Care Center at 4-6, 9, 12, Lorantffy, 999 F. Supp. 1037 \(No. 97-CV-00295\)](#). The nursing home also argued that it had admitted three African Americans since opening its doors in 1971. It is unclear about the circumstances of those residents, but one of the former residents served as one of the government's witnesses and presented evidence of being racially discriminated against.

[FN3]. Several research studies show that even when payment status is controlled there are still significant inequities in access and quality of nursing home care that are only explained based on a difference in the patient's race. Vincent Mor et al., [Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care](#), 82 *Milbank Q.* 227, 237 (2004); David C. Grabowski, [The Admission of Blacks to High-Deficiency Nursing Homes](#), 42 *Med. Care* 456, 458 (2004); see Vernellia R. Randall, [Racial Discrimination in Health Care in the United States as a Violation of the International Convention on the Elimination of All Forms of Racial Discrimination](#), 14 *U. Fla. J.L. & Pub. Pol'y* 45, 47-65 (2002); Mary L. Fennell et al., [Facility Effects on Racial Differences in Nursing Home Quality of Care](#), 15 *Am. J. Med. Quality* 174, 174-76 (2000); David Falcone & Robert Broyles, [Access to Long-term Care: Race as a Barrier](#), 19 *J. Health Pol. Pol'y & L.* 583, 588-92 (1994); David Barton Smith, [The Racial Integration of Health Facilities](#), 18 *J. Health Pol. Pol'y & L.* 851, 862-63 (1993); William G. Weissert & Cynthia Matthews Cready, [Determinants of Hospital-to-Nursing Home Placement Delays: A Pilot Study](#), 23 *Health Servs. Res.* 619, 632, 642 (1988).

[FN4]. Based on the empirical data, researchers have argued that the actions of the nursing homes are blatantly and intentionally discriminatory. Fennell et al., *supra* note 3, at 174; Falcone & Broyles, *supra* note 3, at 583; Smith, *supra* note 3, at 852; Weissert & Cready, *supra* note 3, at 619. Furthermore, Professor Sidney Watson also notes the lack of any other reasonable explanation for the continued racial segregation and inequities in care at nursing homes is evidence of intentional racial discrimination. Sidney D. Watson, [Health Care in the Inner City: Asking the Right Question](#), 71 *N.C. L. Rev.* 1647, 1668 n.103 (1993).

[FN5]. See Civil Rights Act of 1964, 42 U.S.C. §§ 2000d to 2000d-1 (2000).

[FN6]. Fennell et al., *supra* note 3, at 174; Falcone & Broyles, *supra* note 3, at 591-93; Smith, *supra* note 3, at 857, 860-61; Steven P. Wallace, [The Political Economy of Health Care for Elderly Blacks](#), 20 *Int'l J. Health Servs.* 665, 677 (1990); N.Y. State Advisory Comm. to the U.S. Comm'n on Civil Rights, [Minority Elderly Access to Health Care and Nursing Homes \(1992\)](#) (presentation of Arthur O. Eve, New York State Assembly Deputy Speaker) [hereinafter *N.Y. State Advisory Comm., Minority Elderly Access*]; Weissert & Cready, *supra* note 3, at 642, 645.

[FN7]. Mor et al., *supra* note 3; Grabowski, *supra* note 3; Daniel L. Howard et al., [Distribution of African Americans in Residential Care/Assisted Living and Nursing Homes: More Evidence of Racial Disparity?](#), 92 *Am. J. Pub. Health* 1272, 1275 (2002); Robert S. Levine et al., [Black-White Inequalities in Mortality and Life Expectancy, 1933-1999: Implications for Healthy People 2010](#), 116 *Pub. Health Rep.* 474, 475, 480-482 (2001); Jim Mitchell et al., [Difference by Race in Long-Term Care Plans](#), 19 *J. Applied Gerontology* 424, 425 (2000); Marian E. Gornick et al., [Effects of Race and Income on Mortality and Use of Services Among Medicare Beneficiaries](#), 335 *New Eng. J. Med.* 791, 791-92 (1996). See generally Fennell et al., *supra* note 3; Wallace, *supra* note 6.

[FN8]. U.S. Comm'n on Civil Rights, [Federal Title VI Enforcement to Ensure Nondiscrimination in Federally Assisted Programs 230-31 \(1996\)](#) [hereinafter *U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996)*].

[FN9]. N.Y. State Advisory Comm., *Minority Elderly Access*, supra note 6.

[FN10]. See Hospital Survey and Construction Act, 42 U.S.C. § 291(e) (1946).

[FN11]. *Simkins v. Moses H. Cone Mem'l Hosp.*, 323 F.2d 959 (4th Cir. 1963).

[FN12]. See Civil Rights Act of 1964, 42 U.S.C. §§ 2000d to 2000d-1 (2000).

[FN13]. *Id.*

[FN14]. Ronald Sullivan, *Study Charges Bias in Admission to Nursing Homes*, N.Y. Times, Jan. 28, 1984, at 127 [hereinafter Sullivan, *Study Charges Bias*]; Ronald Sullivan, *New Rules Sought on Nursing Homes*, N.Y. Times, May 5, 1985, at 146 [hereinafter Sullivan, *New Rules Sought*].

[FN15]. See National Research Council of The National Academies, *Critical Perspectives on Racial and Ethnic Differences in Health in Late Life 3* (Norman B. Anderson et al., eds., 2004).

[FN16]. *Id.*

[FN17]. Robert M. Weinick et al., *Racial and Ethnic Differences in Access to and Use of Health Care Services, 1997 to 1996*, 57 *Med. Care Res. & Rev.* 37, 37 (2000).

[FN18]. Gornick, supra note 7, at 791-93.

[FN19]. Activities of daily living (“ADL”) are “basic activities that support survival, including eating, bathing, toileting, dressing, and transferring out of a bed or a chair.” Wan He et al., U.S. Census Bureau, P23-209, *Current Population Reports: 65+ in the United States: 2005*, at 233 (2005) [hereinafter *Current Population Reports*].

[FN20]. Steven P. Wallace et al., *The Persistence of Race and Ethnicity in the Use of Long-term Care*, 53 *J. Gerontology: Psych. Sci. & Soc. Sci.* S104, S104-S107 (1998).

[FN21]. Mor et al., supra note 3, at 237-40.

[FN22]. Falcone & Broyles, supra note 3, at 583; Weissert & Cready, supra note 3, at 619. See also Smith, supra note 3, at 852; Sullivan, *Study Charges Bias*, supra note 14, at 127; Sullivan, *New Rules Sought*, supra note 14, at 146. The denial of admission of elderly African Americans to quality was the basis of two lawsuits: *Taylor v. White*, 132 F.R.D. 636 (E.D. Pa. 1990), a case filed on behalf of nursing home residents challenging the poor quality of care provided African Americans in Philadelphia nursing homes; and *United States v. Lorantffy Care Ctr.*, 999 F. Supp. 1037 (N.D. Ohio 1998). In each instance, the case provided less than a favorable outcome for those discriminated against, which will be discussed in more detail in Section VI.

[FN23]. Mor et al., supra note 3, at 237; Grabowski, supra note 3, at 456; Fennell et al., supra note 3, at 174.

[FN24]. Falcone & Broyles, supra note 3, at 591-93; Smith, supra note 3, at 857, 860-61; N.Y. State Advisory Comm., *Minority Elderly Access*, supra note 6; Weissert & Cready, supra note 3, at 642, 645.

[FN25]. Falcone & Broyles, supra note 3, at 588-92; Weissert & Cready, supra note 3, at 632, 642.

[FN26]. See generally David Barton Smith, *Addressing Racial Inequities in Health Care: Civil Rights Monitoring and Report Cards*, 23 *J. Health Pol., Pol'y & L.* 75, 75-76 (1998); Falcone & Broyles, supra note 3, at

591-93.

[FN27]. Fennell et al., *supra* note 3, at 174.

[FN28]. Scholars question the neutrality of geographic racial segregation and socioeconomic status. See Jacqueline L. Angel & Ronald J. Angel, *Minority Group Status and Healthful Aging: Social Structure Still Matters*, 96 *Am. J. Pub. Health* 1152, 1154 (2006); David R. Williams, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 *Pub. Health Rep.* 404, 404-07 (2001) [hereinafter Williams, *Racial Residential Segregation*]; David R. Williams, *Race, Socioeconomic Status, and Health: The Added Effects of Racism and Discrimination*, 896 *Ann. N.Y. Acad. Sci.* 173, 177-80 (1999) [hereinafter Williams, *Race, Socioeconomic Status, and Health*]; Wallace, *supra* note 6, at 674.

[FN29]. See Wallace, *supra* note 20, at 677.

[FN30]. *Id.*

[FN31]. Mor et al., *supra* note 3, at 235-38; Grabowski, *supra* note 3, at 460-62; Nadereh Pourat et al., *Postadmission Disparities in Nursing Home Stays of Whites and Minority Elderly*, 12 *J. Health Care for the Poor & Underserved* 352, 352-53, 362-63 (2001); Mitchell et al., *supra* note 7, at 425.

[FN32]. Weinick et al., *supra* note 17, at 36-37.

[FN33]. See Fennell et al., *supra* note 3, at 174; Smith, *supra* note 3, at 862-64, 866; Falcone & Broyles, *supra* note 3, at 588-92; Weissert & Cready, *supra* note 3, at 632, 642.

[FN34]. The U.S. Department of Health, Education, and Welfare was renamed the U.S. Department of Health and Human Services (“HHS”) in 1980. See Department of Education Organization Act of 1979, *Pub. L. No. 96-88*, § 509(e), 93 *Stat.* 695 (1979) (codified as 20 *U.S.C.* § 3508 (2000)) [hereinafter HHS].

[FN35]. Mor et al., *supra* note 3; Grabowski, *supra* note 3; Daniel L. Howard et al., *Distribution of African Americans in Residential Care/Assisted Living and Nursing Homes: More Evidence of Racial Disparity?*, 92 *Am. J. Pub. Health* 1272, 1275 (2002); Robert S. Levine et al., *supra* note 7, at 475, 480-482; Fennell et al., *supra* note 3; Jim Mitchell et al., *supra* note 7, at 425, 435-38; Marian E. Gornick, et al., *supra* note 7, at 791-92, 797-98; Wallace, *supra* note 6, at 677-78.

[FN36]. U.S. Comm'n on Civil Rights, *Funding Federal Civil Rights Enforcement* 5 (1995); Comm'n on Civil Rights, *Federal Title VI Enforcement* (1996), *supra* note 8, at 229-31.

[FN37]. N.Y. State Advisory Comm., *Minority Elderly Access*, *supra* note 6.

[FN38]. 45 *C.F.R.* § 80.1 (2005); see also U.S. Comm'n on Civil Rights, *Funding Federal Civil Rights Enforcement*, *supra* note 36, at 14.

[FN39]. Numerous nursing homes have been found out of compliance with Title VI, but instead of initiating legal or administrative action, OCR has only required statements of commitment to stop discriminating against African Americans. U.S. Comm'n on Civil Rights, *Federal Title VI Enforcement* (1996), *supra* note 8, at 230-31. These commitments have been illusionary at best, as African Americans continue to reside in substandard quality nursing homes while Whites reside in higher quality nursing homes. Mor et al., *supra* note 3, at 237.

[FN40]. Mor et al., *supra* note 3, at 227-28; see also 28 *C.F.R.* § 42.406 (2006), 45 *C.F.R.* § 80.6 (2005).

[FN41]. U.S. Comm'n on Civil Rights, *Federal Title VI Enforcement* (1996), *supra* note 8, at 228-32.

[FN42]. All of the Title VI cases have been brought by those affected, including African Americans. These cases have varied from challenging the relocation of hospitals from predominately minority areas to the substandard level of care in health care facilities whose patients are predominately minority. See *Mussington v. St. Luke's-Roosevelt Hosp. Ctr.*, 824 F. Supp. 427 (S.D.N.Y. 1993) (basing decision on procedural deficiencies, court opts to dismiss class action lawsuit challenging the relocation of infant health-related services out of the Harlem area as proof of racial discrimination through disparate impact); *NAACP v. Med. Ctr., Inc.*, 657 F.2d 1322 (3d Cir. 1981) (basing decision on lack of evidence, court dismisses a racial discrimination case challenging the relocation of health services from a predominately African American neighborhood to a predominately White neighborhood); *Jackson v. Conway*, 620 F.2d 680 (8th Cir. 1980) (basing decision on procedural deficiencies, court dismisses class action suit challenging a hospital closure in Missouri as proof of racial discrimination through disparate impact).

[FN43]. See *Taylor v. White*, 132 F.R.D. 636, 639 (E.D. Pa. 1990); *Linton ex rel. Arnold v. Comm'r of Health & Env't*, 779 F. Supp. 925 (M.D. Tenn. 1990) (challenging racial discrimination committed by the state of Tennessee through its policy of limiting the number of Medicaid beds in nursing homes).

[FN44]. *Alexander v. Sandoval*, 532 U.S. 275 (2001). The case was based on a challenge to English-only driver's license applications under Title VI. *Id.* Although the Supreme Court did not discuss the regulation of health care entities under Title VI, the Court's decision applied to the application of sections 601 and 602 that are used as the basis for cases regarding racial discrimination by federally-funded health care facilities. *Id.* at 278-93; see generally Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v. Sandoval*, 3 *Yale J. Health Pol'y L. & Ethics* 215, 243-45 (2003).

[FN45]. U.S. Comm'n on Civil Rights, *Federal Title VI Enforcement* (1996), *supra* note 8, at 230-31

[FN46]. *Id.*

[FN47]. See, e.g., *Madison-Hughes v. Shalala*, 80 F.3d 1121 (6th Cir. 1996).

[FN48]. See Joel Teitelbaum & Sara Rosenbaum, *Medical Care as a Public Accommodation: Moving the Discussion to Race*, 29 *Am. J. L. & Med.* 381, 381 (2003) (recommending extension of public accommodation definition to include private health providers as under the ADA); Smith, *supra* note 3, at 862-63 (recommending that OCR collect racial data and use it to bring administrative actions against health care entities under Title VI).

[FN49]. For further discussion, see Dayna Bowen Matthew, *Disastrous Disasters: Restoring Civil Rights Protections for Victims of the State in Natural Disasters*, 2 *J. Health & Biomed. L.* 213, 234 (2006) [hereinafter Matthew, *Disastrous Disasters*]; Dayna Bowen Matthew, *A New Strategy To Combat Racial Inequality In American Health Care Delivery*, 9 *DePaul J. Health Care L.* 793 (2005) [hereinafter Matthew, *A New Strategy To Combat Racial Inequality*].

[FN50]. There are two types of suits that can be brought under Medicaid: bias and poor quality. In the 1970s and 1980s, elderly African Americans brought lawsuits in Tennessee and Pennsylvania against the government regarding nursing homes' use of Medicaid to racially discriminate against African Americans. See, e.g., *Taylor v. White*, 132 F.R.D. 636 (E.D. Pa. 1990); *Linton ex rel. Arnold v. Comm'r of Health & Env't*, 779 F. Supp. 925 (M.D. Tenn. 1990). The lawsuits asserted that the state Medicaid bed certification policies allowed nursing homes to deny African American Medicaid patients admission because the nursing home did not have any Medi-

caid beds, but if a White Medicaid patient sought admission then another Medicaid bed would be certified. Thus, nursing homes used Medicaid as a proxy to deny African Americans admission, based on neutral policies, in violation of Title VI. Private parties' legal rights to bring disparate impact claims under Title VI were eviscerated by the Supreme Court in *Alexander v. Sandoval*. Because in the past Medicaid bias claims used the theory of disparate impact to racial discrimination, it is unclear whether private parties can file Medicaid bias claims against the government to address racial discrimination in health care. Therefore, this article will only discuss the government's failure to provide quality health care as required under the Medicaid Act.

[FN51]. See *United States v. Lorantffy Care Ctr.*, 999 F. Supp. 1037, 1040 (N.D. Ohio 1998).

[FN52]. See Ruqaiijah Yearby, *Is It Too Late for Title VI Enforcement?-- Seeking Redemption of the Unequal United States' Long Term Care System Through International Means*, 9 *DePaul J. Health Care L.* 971, 973 (2005), for a detailed discussion of the application of CERD to racial discrimination in nursing homes.

[FN53]. See Matthew, *Disastrous Disasters*, supra note 49; Matthew, *A New Strategy To Combat Racial Inequality*, supra note 49, at 793; see Teitelbaum & Rosenbaum, supra note 48, at 381 (recommending extension of public accommodation definition to include private health providers as under ADA).

[FN54]. See Vernellia Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 *St. Louis U. Pub. L. Rev.* 191, 196-98 (1996).

[FN55]. According to Professor David Smith, private health insurance developed in the United States as a mechanism to prevent racially integrated single payer health insurance. David Barton Smith, *Health Care Divided: Race and Healing a Nation* 29 (1999).

[FN56]. *Id.*

[FN57]. Randall, supra note 54, at 196-98.

[FN58]. Smith, supra note 55, at 29.

[FN59]. *Id.* at 29-30.

[FN60]. See Hospital Survey and Construction Act, 42 U.S.C. § 291e(f) (2000).

[FN61]. Smith, supra note 55, at 239-40.

[FN62]. *Id.*

[FN63]. Institute of Medicine, *Improving the Quality of Care in Nursing Homes*, 238, app. A (1986) [hereinafter IOM Report].

[FN64]. See *id.* This prohibition was repealed in 1950 as part of the amendments to the SSA. *Id.*

[FN65]. See *id.*

[FN66]. Smith, supra note 55, at 242. Only a small number of wealthy African Americans gained access to nursing homes by being housed in private facilities. *Id.*

[FN67]. David Barton Smith, *Population Ecology and the Racial Integration of Hospitals and Nursing Homes in*

the United States, 68 Milbank Q. 561, 577 (1990).

[FN68]. See Smith, *supra* note 55, at 241.

[FN69]. See Hospital Survey and Construction Act, 42 U.S.C. § 291e(f) (2000).

[FN70]. Smith, *supra* note 55, at 241.

[FN71]. See Hospital Survey and Construction Act § 291e(f).

[FN72]. *Id.* (emphasis added). This further supported the “separate but equal” paradigm accepted at the time, but this was rejected by the Supreme Court in the landmark case of *Brown v. Board of Education*, 349 U.S. 294 (1955).

[FN73]. *Simkins v. Moses H. Cone Mem'l Hosp.*, 323 F.2d 959, 968 (4th Cir. 1963).

[FN74]. U.S. Comm'n on Civil Rights, Civil Rights 130 (1963).

[FN75]. *Id.* When a separate but equal plan was in place, the hospital's application indicated how the hospital planned to separate the races. *Id.* at 130-31.

[FN76]. *Id.* at 130-32. The states were Alabama, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Virginia, and West Virginia. *Id.* at 130.

[FN77]. See *id.* at 132.

[FN78]. 323 F.2d 959 (1963).

[FN79]. See generally Derrick Bell, Jr., *Brown v. Board of Education and the Interest-Convergence Dilemma*, 93 Harv. L. Rev. 518 (1980).

[FN80]. See generally Smith, *supra* note 55.

[FN81]. *Simkins*, 323 F.2d at 960-61.

[FN82]. Smith, *supra* note 55, at 115-16.

[FN83]. 349 U.S. 294 (1955) (holding racial segregation of schools was unconstitutional).

[FN84]. *Simkins*, 323 F.2d at 959.

[FN85]. U.S. Comm'n on Civil Rights, Civil Rights 132 (1963). From 1954 to 1960, there were thirty-one racially segregated hospitals in North Carolina that received Hill-Burton funding. *Id.* Four of the thirty-one facilities were designated as African American only. *Id.* Two additional grants were made by North Carolina in 1961 and 1962 for construction of two more White-only facilities. *Id.* at 133.

[FN86]. *Simkins*, 323 F.2d at 960. The two hospitals sued were Moses H. Cone Memorial Hospital and Wesley Long Community Hospital. *Id.*

[FN87]. *Id.* at 963.

[FN88]. *Id.* at 967-69. Each of the North Carolina hospitals' applications for Hill-Burton funds were based on a "separate but equal" plan and stated, "[C]ertain persons in the area will be denied admission to the proposed facilities as patients because of race, creed or color." *Id.* at 962. Based on this record, it was clear that the hospitals discriminated based on race. Hence, the central issue in the case was whether the hospitals' receipt of federal funding and subjugation to "elaborate and intricate pattern of governmental regulation, both state and federal" made the hospitals state actors. *Id.* at 964. Being classified as a state actor meant that the hospitals were prohibited from discriminating against African Americans under the Equal Protection Clause. *Id.* at 965-66.

[FN89]. *Id.* at 963. By the time the case was commenced, Moses H. Cone Memorial Hospital had received \$1.27 million and Wesley Long Community Hospital had received \$1.95 million. *Id.* These appropriations supporting racial discrimination were made, for the most part, after the Supreme Court's decision in *Brown v. Board of Education*. *Id.*

[FN90]. *Id.* at 967.

[FN91]. *Id.* at 969. The court ruled that the language violated the 5th and 14th Amendments of the U.S. Constitution. *Id.* at 969-70.

[FN92]. See *id.* at 968-69.

[FN93]. *Id.* at 969.

[FN94]. Smith, *supra* note 55, at 100-02.

[FN95]. *Id.* at 236-75.

[FN96]. See generally *id.*

[FN97]. *S. Rep. No. 88-872 (1964)*, reprinted in 1964 U.S.C.C.A.N. 2355, 2363 (emphasis added).

[FN98]. Smith, *supra* note 55, at 100.

[FN99]. U.S. Comm'n on Civil Rights, *Federal Title VI Enforcement (1996)*, *supra* note 8, at 24.

[FN100]. *Id.* at 25.

[FN101]. See *Cannon v. Univ. of Chicago*, 441 U.S. 677, 694 (1979) (holding that there was a private right of action under Title IX of the Educational Amendment of 1972). Because Title IX was patterned after Title VI of the Civil Rights Act, the Court "embraced the existence of a private right under Title VI." *Alexander v. Sandoval*, 532 U.S. 275, 280 (2001).

[FN102]. See Civil Rights Act of 1964, 42 U.S.C. § 2000d (2000).

[FN103]. Physicians receiving payments under Medicare Part B are exempted from compliance with Title VI because these payments are not defined as federal financial assistance. Smith, *supra* note 55, at 164. Thus, physicians can continue to discriminate based on race. *Id.* Although not discussed in this Article, government funding of physicians that racially discriminate is a violation of domestic and international law. See generally Randall, *supra* note 3, for a detailed discussion.

[FN104]. *Alexander v. Choate*, 469 U.S. 287 (1985).

[FN105]. Civil Rights Act of 1964, [42 U.S.C. § 2000d-1 \(2000\)](#).

[FN106]. See *id.*

[FN107]. However, HHS has not revised the regulations to include changes made by the Civil Rights Restoration Act of 1987 and has not addressed block grant programs. Therefore, states regulate all Title VI compliance by Medicaid certified facilities. See U.S. Comm'n on Civil Rights, *Federal Title VI Enforcement* (1996), *supra* note 8, at 224. HHS issued a proposed rule on nondiscrimination requirements for block grants in 1986, but never issued a final rule. *Id.* Nevertheless, HHS has failed to monitor state regulation of Title VI compliance under Medicaid. *Id.* at 232.

[FN108]. See Title VI Regulations, 29 Fed. Reg. 16,298 (Dec. 4, 1964). These regulations were amended in 1973. See 38 Fed. Reg. 17,979 (July 5, 1973). In 1965, the task of enforcing these regulations was granted to HHS's Office of Equal Health Opportunity ("OEHO"). Smith, *supra* note 55, at 128. OEHO was instrumental in the racial desegregation of hospitals, *id.* at 141, but was disbanded two years later before desegregating nursing homes. *Id.* at 159-61.

[FN109]. Smith, *supra* note 26, at 86.

[FN110]. U.S. Comm'n on Civil Rights, *Federal Title VI Enforcement* (1996), *supra* note 8, at 219.

[FN111]. *Id.*

[FN112]. *Id.*

[FN113]. [45 C.F.R. § 80.3\(b\)\(vii\)\(2\) \(2005\)](#) (noting discrimination is prohibited) (emphasis added).

[FN114]. [45 C.F.R. § 80.6\(b\) \(2005\)](#) (detailing compliance information).

[FN115]. Civil Rights Act of 1964, [42 § 2000d-1 \(2000\)](#) (emphasis added). Additionally, the regulations state that OCR must "to the fullest extent practicable seek the cooperation of recipients in obtaining compliance with this part and shall provide assistance and guidance to recipients to help them comply voluntarily with this part." [45 C.F.R. § 80.6\(a\) \(2005\)](#) (detailing compliance information).

[FN116]. When termination from the Medicare and Medicaid program is the only government option, the trend has been for the government to try to avoid imposing termination by allowing nursing homes to voluntarily comply with the applicable regulations. Under Title VI, the only remedy available to the government is termination, and thus the government tries to obtain cooperation through voluntary compliance. This same trend was seen in the government's survey and certification of nursing homes until 1986, when the government implemented new remedies such as civil money penalties. See *Skilled Nursing Facilities*, 39 Fed. Reg. 2238-2257 (Jan. 17, 1974); [42 C.F.R. § 442.118 \(1986\)](#). Now the government actively regulates nursing homes and rarely gives them an opportunity to correct violations through voluntary compliance. See [42 C.F.R. § 498.60 \(2005\)](#).

[FN117]. Smith, *supra* note 55, at 236.

[FN118]. See Civil Rights Act of 1964, [42 U.S.C. § 2000d \(2000\)](#).

[FN119]. See Smith, *supra* note 55, at 159-61.

[FN120]. Medicare is a federal entitlement program to pay for health insurance for the elderly and disabled. See

Social Security Act, 42 U.S.C. § 1395 (2000).

[FN121]. Medicaid is a state- and federally-funded program to pay for medical assistance for the poor. The states administer this program. See id. § 1396.

[FN122]. See generally id. §§ 1395c to 1395w-28.

[FN123]. See id. § 1395x(i).

[FN124]. Id. § 1395d(a)(2)(A). However, Part A does not cover any nursing home services if the patient who requires skilled nursing or skilled rehabilitation services can receive these services on an outpatient basis. See id. § 1395k.

[FN125]. See id. § 1396a.

[FN126]. For a detailed discussion concerning qualifying for Medicaid, see Kaiser Comm'n on Medicaid and the Uninsured, Paying for Nursing Home Care: Assets Transfer and Qualifying for Medicaid 1-2 (2006), <http://www.kff.org/medicaid/upload/7452.pdf>.

[FN127]. Smith, supra note 55, at 143-59.

[FN128]. Id. at 159-63, 236-52.

[FN129]. Smith, supra note 67, at 576.

[FN130]. Currently, three main parties fund nursing homes: Medicare, Medicaid, and private parties. Even though nursing homes still prefer private pay patients, Medicaid pays for the majority of care. Of the payments received by nursing homes in 2001, Medicare accounted for 11.7%, Medicaid for 47.5%, and private payors (including out-of-pocket, private health insurance, and other private funds) were responsible for 38.5%. See Ctrs. for Medicare & Medicaid Servs., Nat'l Health Expenditure Projections: 2006-2013, tbl. 13 (Nursing Home Care Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Selected Calendar Years 2001-2016) <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj/2006.pdf> (last visited Jan. 27, 2006). Medicare spending on nursing home care totaled \$9.5 billion in 2000 and \$11.6 billion in 2001. Id.

[FN131]. Smith, supra note 55, at 159-63, 236-52.

[FN132]. Id.

[FN133]. Id. at 160.

[FN134]. Id. at 159-60.

[FN135]. See id. at 236.

[FN136]. See Smith, supra note 67, at 576-77.

[FN137]. Id.

[FN138]. A substandard nursing home is one that has violated one of the Medicare or Medicaid regulations regarding resident behavior and facility practices, quality of life, or quality of care that caused actual harm or seri-

ous actual harm to one or more nursing home residents. 42 C.F.R. § 488.301 (2005) (defining substandard quality of care).

[FN139]. See Smith, *supra* note 55, at 239-41.

[FN140]. 42 C.F.R. § 488.308(a)-(b) (2005) (discussing survey frequency).

[FN141]. 42 C.F.R. §§ 488.300-.335 (2005) (Subpart E--Survey & Certification of Long-Term Care Facilities).

[FN142]. This survey is called an annual standard survey. There are three other types of surveys: complaint, revisit, and extended standard survey. See 42 C.F.R. §§ 488.308-.310 (2005) (discussing survey frequency, extended survey).

[FN143]. 42 C.F.R. § 488.314 (2005) (discussing survey teams).

[FN144]. See Social Security Act, 42 U.S.C. § 1395i-3(g)(2)(A) (2000). The majority of nursing homes are also certified to participate in the Medicaid program. See 42 C.F.R. § 488.300 (2005). Thus, the survey team usually cites the nursing home for both Medicare and Medicaid violations. 42 C.F.R. § 488.330(a)(1)(i), (b) (2005).

[FN145]. 42 C.F.R. § 488.301 (2005). A deficiency or citation is a violation of the Medicare or Medicaid participation requirements found in the program regulations. *Id.* There are a total of 190 possible Medicare deficiencies, divided into seventeen different categories, for which HHS can cite a nursing home. See Dep't Health Human Servs., OEI-02-01-00600, Nursing Home Deficiency Trends and Survey and Certification Process Consistency 1 (2003), <http://oig.hhs.gov/oei/reports/oei-02-01-00600.pdf>. Most deficiencies are categorized into three main areas: quality of care, 42 C.F.R. § 483.25 (2005); quality of life, 42 C.F.R. § 483.15 (2005); and resident behavior and facility practice, 42 C.F.R. § 483.13 (2005). Medicaid regulations are based exclusively on the Medicare regulations, but differ slightly on specific deficiency number designations.

[FN146]. 42 C.F.R. § 488.404(a) (2005).

[FN147]. 42 C.F.R. § 488.404(b) (2005). The scope of the deficiency means whether the deficiency was isolated, constituted a pattern of behavior, or was widespread. 42 C.F.R. § 488.404(b)(2) (2005). The severity of the deficiency depends on whether a facility's deficiencies caused: "(i) No actual harm with a potential for minimal harm; (ii) [N]o actual harm with a potential for more than minimal harm, but not immediate jeopardy; (iii) [A]ctual harm that is not immediate jeopardy; or (iv) [I]mmediate jeopardy to a resident's health or safety." 42 C.F.R. § 488.404(b)(1) (2005).

[FN148]. 42 C.F.R. § 488.404(b).

[FN149]. Grabowski, *supra* note 3, at 456.

[FN150]. 42 C.F.R. §§ 488.330(d) (2005).

[FN151]. See Social Security Act, 42 U.S.C. § 1395i-3(g)(5) (2000).

[FN152]. Encyclopedia of American Industries, SIC 8051 Skilled Nursing Care Facilities, <http://www.referenceforbusiness.com/industries/Service/Skilled-Nursing-Care-Facilities.html> (last visited Feb. 23, 2006). Medicare spending on nursing home care totaled \$9.5 billion in 2000 and \$11.6 billion in 2001. Ctrs. for Medicare & Medicaid Servs., *supra* note 130, at tbl.13.

[FN153]. Howard et al., *supra* note 7, at 1275.

[FN154]. *Id.*; see Fennell et al., *supra* note 3, at 175; Wallace, *supra* note 6, at 672-76.

[FN155]. Weinick et al., *supra* note 17, at 51.

[FN156]. *Id.* At least one-half to three-quarters of the racial inequities of care are not explained by income and health insurance. *Id.*

[FN157]. Arline T. Geronimus et al., “Weathering” and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States, 96 *Am. J. Public Health* 826, 826 (2006); Williams, Race, Socioeconomic Status and Health, *supra* note 28, at 184; See Wallace, *supra* note 20, at S104-S105; See Gornick, *supra* note 6, at 791; N.Y. State Advisory Comm., Minority Elderly Access, *supra* note 6, at ii-iii (transmittal letter).

[FN158]. Eric C. Schneider et al., Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care, 287 *J. Am. Med. Ass'n* 1288, 1290 (2002).

[FN159]. See Wallace, *supra* note 20, at S104-S106.

[FN160]. See Gornick, *supra* note 7, at 798.

[FN161]. See Williams, Race, Socioeconomic Status and Health, *supra* note 28, at 184.

[FN162]. See Gornick, *supra* note 7, at 791-92.

[FN163]. See Wallace, *supra* note 6, at 677. Empirical data show that this disparity in care is not attributable to African American desire for family care compared to Whites. See Mitchell et al., *supra* note 7, at 435-36.

[FN164]. Wallace, *supra* note 6, at 667.

[FN165]. *Id.*

[FN166]. Mor et al., *supra* note 3, at 237-38; Grabowski, *supra* note 3, at 460-62; Pourat et al., *supra* note 31, at 352-53, 362-63; Mitchell et al., *supra* note 7, at 425.

[FN167]. Based on the empirical data, researchers have argued that the actions of the nursing homes are blatantly and intentionally discriminatory. Fennell et al., *supra* note 3, at 174; Falcone & Broyles, *supra* note 3, at 583; Smith, *supra* note 3, at 852; Weissert & Cready, *supra* note 3, at 619; N.Y. State Advisory Comm., Minority Elderly Access, *supra* note 6, at 19; U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 230-31.

[FN168]. Fennell et al., *supra* note 3, at 174; Falcone & Broyles, *supra* note 3, at 583-92; Smith, *supra* note 3, at 862-63, 866; Weissert & Cready, *supra* note 3, at 632-42.

[FN169]. Joseph Angelleli et al., Effect of Educational Level and Minority Status on Nursing Home Choice After Hospital Discharge, 96 *Am. J. Pub. Health* 1249, 1249 (2006); Smith, *supra* note 55, at 240-42; Smith, *supra* note 3, at 862-63, 866.

[FN170]. Weissert & Cready, *supra* note 3, at 619-20.

[FN171]. Wallace, *supra* note 6, at 677.

[FN172]. Sullivan, *Study Charges Bias*, supra note 14, at 127; Sullivan, *New Rules Sought*, supra note 14, at 146; Smith, supra note 3, at 852-67; Falcone & Broyles, supra note 3, at 585-92; Weissert & Cready, supra note 3, at 645.

[FN173]. Wallace, supra note 6, at 677.

[FN174]. Grabowski, supra note 3, at 456.

[FN175]. Fennell et al., supra note 3, at 174.

[FN176]. National statistics show “[a]bout 32 percent entered from a private residence, 45 percent were admitted from a hospital, and about 12 percent were admitted from another nursing home.” *Current Population Reports*, supra note 19, at 68.

[FN177]. N.Y. State Advisory Comm., *Minority Elderly Access*, supra note 6, at 19.

[FN178]. See Falcone & Broyles, supra note 3, at 583.

[FN179]. *Id.* at 588-92; Weissert & Cready, supra note 3, at 642, 645; N.Y. State Advisory Comm., *Minority Elderly Access*, supra note 6, at 19.

[FN180]. Falcone & Broyles, supra note 3, at 584.

[FN181]. Empirical studies conducted in North Carolina and New York show that African Americans experience delays in transfer to quality nursing homes because they are denied admission to quality nursing homes based on their race. See Falcone & Broyles, supra note 3, at 588-92; N.Y. State Advisory Comm., *Minority Elderly Access*, supra note 6, at 19; Sullivan, *Study Charges Bias*, supra note 14; Sullivan, *New Rules Sought*, supra note 14.

[FN182]. Falcone & Broyles, supra note 3, at 585 (noting delay averaged 10.7 days); see Smith, supra note 3, at 857-61; David Falcone & Robert Broyles, *What Types of Hospital; Patients Wait for Alternative Placement*, 5 *Aging & Soc. Pol’y* 77 (1993) (noting delay averaged eleven days); S.L. Ettner, *Do Elderly Medicaid Patients Experience Reduced Access to Nursing Home Care?*, 121 *J. Health Econ.* 259 (1993); David Falcone et al., *Waiting for Placement: An Explanatory Analysis of Determinants of Delayed Hospital Discharge of Elderly Patients*, 26 *Health Servs. Res.* 339, 340 (1991).

[FN183]. Falcone & Broyles, supra note 3, at 584.

[FN184]. *Id.* at 583.

[FN185]. See N.Y. State Advisory Comm., *Minority Elderly Access*, supra note 6, at 19.

[FN186]. Falcone & Broyles, supra note 3, at 591-93.

[FN187]. Wallace, supra note 6, at 676-77.

[FN188]. Falcone & Broyles, supra note 3, at 591-93.

[FN189]. See Smith, supra note 3, at 854.

[FN190]. Grabowski, supra note 3, at 462.

[FN191]. States regulate the admission process by restricting the number of Medicaid certified nursing home beds. *Id.*

[FN192]. *See id.*

[FN193]. Weissert & Cready, *supra* note 3, at 642, 645.

[FN194]. *Id.*

[FN195]. *Id.*

[FN196]. *See* Sullivan, Study Charges Bias, *supra* note 14, at 127; Sullivan, New Rules Sought, *supra* note 14, at 146.

[FN197]. *See* Wallace, *supra* note 6, at 677.

[FN198]. *Id.*

[FN199]. *See* generally N.Y. State Advisory Comm., Minority Elderly Access, *supra* note 6.

[FN200]. *Id.* at 5.

[FN201]. *Id.* at 37-38 (citing Jeffrey Amber, Executive Director of Friends and Relatives of the Institutionalized Aging).

[FN202]. *Id.*

[FN203]. *See* Grabowski, *supra* note 3, at 456.

[FN204]. Wallace, *supra* note 6, at 677.

[FN205]. 42 C.F.R. § 483.25 (2005) (defining quality of care).

[FN206]. Fennell et al., *supra* note 3, at 174.

[FN207]. *See* Grabowski, *supra* note 3, at 456; Smith, *supra* note 3, at 861; Mor et al., *supra* note 3, at 237.

[FN208]. Fennell et al., *supra* note 3, at 174.

[FN209]. *Id.*

[FN210]. 42 C.F.R. § 483.20 (2005) (discussing resident assessment).

[FN211]. Fennell et al., *supra* note 3, at 176.

[FN212]. *Id.*

[FN213]. *Id.*

[FN214]. Grabowski, *supra* note 3, at 456.

[FN215]. *Id.*

[FN216]. See generally Mor et al., *supra* note 3.

[FN217]. See *id.* at 237.

[FN218]. See *id.*

[FN219]. Grabowski, *supra* note 3, at 460. This study also reviewed socioeconomic status and found that Medicaid and Medicare patients were admitted to poor quality facilities. *Id.*

[FN220]. See Mor et al., *supra* note 3, at 245.

[FN221]. *Id.* at 246 fig.2. This ratio varies by state from zero to nine, and the only state where the ratio is zero is Kentucky. *Id.*

[FN222]. *Id.* at 246.

[FN223]. *Id.* at 242-44 fig.2.

[FN224]. See generally *id.*

[FN225]. Wallace, *supra* note 20, at S104-S106.

[FN226]. *Id.*

[FN227]. See generally Mor et al., *supra* note 3; see also Grabowski, *supra* note 3, at 460-62; Pourat et al., *supra* note 31, at 352-53, 362-63; Mitchell et al., *supra* note 7, at 425; Williams, Racial Residential Segregation, *supra* note 28, at 404; Williams, Race, Socioeconomic Status and Health, *supra* note 28, at 174-75; Wallace, *supra* note 20, at S104-S106; Wallace, *supra* note 6, at 672-76.

[FN228]. Fennell et al., *supra* note 3, at 174; Falcone & Broyles, *supra* note 3, at 588-92; Smith, *supra* note 3, at 852; Weissert & Cready, *supra* note 3, at 642, 645.

[FN229]. Levine et al., *supra* note 7, at 475, 480-82; Weinick et al., *supra* note 17, at 36; Robert Blendon et al., Access to Medical Care for Black and White Americans--A Matter of Continuing Concern, 261 J. Am. Med. Ass'n 278, 278-79 (1989).

[FN230]. Wallace, *supra* note 20, at S104-S106.

[FN231]. *Id.*

[FN232]. Mitchell et al., *supra* note 7, at 425; Institute of Medicine, Health Care in a Context of Civil Rights 100 (Nat'l Acad. Press 1981).

[FN233]. Falcone & Broyles, *supra* note 3, at 588-92; Smith, *supra* note 3, at 852; Weissert & Cready, *supra* note 3, at 632, 642.

[FN234]. Falcone & Broyles, *supra* note 3, at 588-92

[FN235]. See Trial Brief of Lorantffy Care Center, *supra* note 2, at 4-5, 9-10. The plaintiff also submitted other arguments, such as the potential in payment differences of the testers. The problems with the nursing homes' arguments will be reviewed in Section VI and in a future article by the author discussing the use of the Fair Housing Act to put an end to the use of racial discrimination in nursing home admission.

[FN236]. See *id.*; Trial Brief of United States, *supra* note 1, at 4-14.

[FN237]. N.Y. State Advisory Comm., *Minority Elderly Access*, *supra* note 6, at ii-iii (transmittal letter); Sullivan, *Study Charges Bias*, *supra* note 14, at 127; Sullivan, *New Rules Sought*, *supra* note 14, at 146.

[FN238]. N.Y. State Advisory Comm., *Minority Elderly Access*, *supra* note 6.

[FN239]. See Smith, *supra* note 3, at 862.

[FN240]. Wallace, *supra* note 6, at 674-76; see generally Williams, *Racial Residential Segregation*, *supra* note 28, at 404; Williams, *Race, Socioeconomic Status and Health*, *supra* note 28, at 174-75.

[FN241]. Wallace, *supra* note 6, at 672-76.

[FN242]. Fennell et al., *supra* note 3, at 174.

[FN243]. *Id.* at 179-80. Kansas was the only state that did not show these inequities. *Id.*

[FN244]. Angel & Angel, *supra* note 28, at 1154; Williams, *Racial Residential Segregation*, *supra* note 28, at 404-07; Williams, *Race, Socioeconomic Status, and Health*, *supra* note 28, at 177-80; Wallace, *supra* note 6, at 674.

[FN245]. Williams, *Race, Socioeconomic Status, and Health*, *supra* note 28, at 178. See also Clear and Convin-
cing Evidence: Measurement of Discrimination in America (Michael Fix & Raymond J. Struyk eds., Urban Inst.
Press 1993) (outlining empirical study cited by the Supreme Court in [Gratz v. Bollinger](#), 539 U.S. 244 (2003),
and [Adarand Constr., Inc. v. Peña](#), 515 U.S. 200 (1995), to show the continuation of racial discrimination in the
United States); Douglas S. Massey & Nancy A. Denton, *American Apartheid: Segregation and the Making of the
Underclass* (Harvard University Press 1993) (providing evidence from an earlier published study that demon-
strates the continuation of racial discrimination in housing), noted in John Iceland et al., U.S. Census Bureau,
CENSR-3, *Racial and Ethnic Residential Segregation in the United States: 1980-2000* (2002); Wallace, *supra*
note 6, at 674. See generally Leland Ware, [The Demographics of Desegregation: Residential Segregation Re-
mains High 40 Years After The Civil Rights Act of 1964](#), 49 *St. Louis U. L.J.* 1155 (2005); Leland Ware, [Race
and Urban Space: Hypersegregated Housing Patterns and the Failure of School Desegregation](#), 9 *Widener L.
Symp. J.* 55 (2003); Leland B. Ware, [New Weapons for an Old Battle: The Enforcement Provisions of the 1988
Amendments to the Fair Housing Act](#), 7 *Admin. L.J. Am. U.* 59. (1993); David Delaney, *Race, Place, & the
Law: 1836-1948* 145, 144-47 (1998).

[FN246]. Williams, *Race, Socioeconomic Status, and Health*, *supra* note 28, at 178.

[FN247]. Innumerable scholars, such as Steven Wallace and David Williams, believe that the theories of geo-
graphic racial segregation and socioeconomic status are two sides of the same coin. See Williams, *Racial Resid-
ential Segregation*, *supra* note 28, at 404-07; Wallace, *supra* note 6, at 672-78. The lack of economic opportuni-
ties available to African Americans perpetuates geographic racial segregation and racial inequities in health care.
See Williams, *Racial Residential Segregation*, *supra* note 28, at 404-07; Wallace, *supra* note 6, at 672-78.

[FN248]. See, e.g., Williams, *Racial Residential Segregation*, *supra* note 28, at 404-07 (discussing the supposi-
tion that socioeconomic status is more predictive than racial differences); see also Williams, *Race, Socioeco-
nomic Status, and Health*, *supra* note 28, at 178; Blendon et al., *supra* note 229, at 278-79 (regarding the supposi-
tion that racial status is more predictive than socioeconomic differences); S.M. Miller, *Race in the Health of*

America, 65 Milbank Q. 500, 523 (1987).

[FN249]. Williams, Race, Socioeconomic Status, and Health, supra note 28, at 174-78.

[FN250]. Wallace, supra note 6, at 678.

[FN251]. Mor et al., supra note 3, at 238; Grabowski, supra note 3, at 460-62; Pourat et al., supra note 31, at 352-53, 362-63; Mitchell et al., supra note 7, at 425; Williams, Racial Residential Segregation, supra note 28, at 404; see generally Williams, Race, Socioeconomic Status and Health, supra note 28, at 174-75; Wallace et al., supra note 20, at S104-S106; Wallace, supra note 6, at 672-78.

[FN252]. Weissert & Cready, supra note 3, at 632, 642.

[FN253]. Id.

[FN254]. Id.

[FN255]. See Smith, supra note 3, at 860-63.

[FN256]. See Wallace, supra note 6, at 672-78.

[FN257]. See generally Sullivan, Study Charges Bias, supra note 14, at 127.

[FN258]. Id.; N.Y. State Advisory Comm., Minority Elderly Access, supra note 6, at ii-iii (transmittal letter); see Sullivan, New Rules Sought, supra note 14, at 146.

[FN259]. See *Linton ex rel. Arnold v. Comm'r of Health & Env't*, 779 F. Supp. 925, 927 (M.D. Tenn. 1990).

[FN260]. See *id.* at 932, 935.

[FN261]. See Wallace, supra note 6, at 677-78; Smith, supra note 3, at 860-63; Fennell et al., supra note 3, at 175, 178; Falcone & Broyles, supra note 3, at 588-92.

[FN262]. See generally Wallace, supra note 20.

[FN263]. See generally *id.*

[FN264]. See generally Mor et al., supra note 3; Grabowski, supra note 3; Williams, Race, Socioeconomic Status, and Health, supra note 28; Wallace, supra note 20; see Pourat et al., supra note 31, at 352-53, 362-63; Mitchell et al., supra note 7, at 425; Williams, Racial Residential Segregation, supra note 28, at 404; Wallace, supra note 6, at 672-78.

[FN265]. Based on the empirical data, researchers have argued that the actions of the nursing homes are blatantly and intentionally discriminatory. See Fennell et al., supra note 3, at 174; see also Falcone & Broyles, supra note 3, at 588-92; Smith, supra note 3, at 852; Weissert & Cready, supra note 3, at 642, 645.

[FN266]. See Falcone & Broyles, supra note 3, at 591-92; Weissert & Cready, supra note 3, at 642, 645.

[FN267]. See Fennell et al., supra note 3, at 174; Smith, supra note 26, at 85-88.

[FN268]. Falcone & Broyles, supra note 3, at 585-87; Weissert & Cready, supra note 3, at 632-42 (1988).

[FN269]. *Taylor v. White*, 132 F.R.D. 636, 647 (E.D. Pa. 1990).

[FN270]. See N.Y. State Advisory Comm., *Minority Elderly Access*, supra note 6, at ii-iii (transmittal letter); Sullivan, *Study Charges Bias*, supra note 14, at 127; Sullivan, *New Rules Sought*, supra note 14, at 146.

[FN271]. Since the passage of the Civil Rights Act, racial discrimination has changed from blatant measures to more refined decisions that include race but are couched in subtle terms. The author is currently working on a piece discussing what constitutes disparate treatment in health care. The distinction is important because if a private party wants to file an action for racial discrimination under Title VI the only claim is for disparate treatment. *Alexander v. Sandoval*, 532 U.S. 275 (2001). For a detailed discussion regarding filing private claims under Title VI and case precedent, see Matthew, *Disastrous Disasters*, supra note 49; Matthew, *A New Strategy To Combat Racial Inequality*, supra note 49, at 796.

[FN272]. See Civil Rights Act of 1964, 42 U.S.C. § 2000d (2000).

[FN273]. Falcone & Broyles, supra note 3, at 585-92; Weissert & Cready, supra note 3, at 632, 642.

[FN274]. See Weissert & Cready, supra note 3, at 632, 642.

[FN275]. See *id.*

[FN276]. Mor et al., supra note 3, at 237-38.

[FN277]. Falcone & Broyles, supra note 3, at 591-93.

[FN278]. *Id.*

[FN279]. *Id.* at 592.

[FN280]. *Id.*

[FN281]. *Id.*

[FN282]. *Id.*

[FN283]. *Id.*

[FN284]. See generally Mor et al., supra note 3; Grabowski, supra note 3; Howard et al., supra note 7; Levine et al., supra note 7; Fennell et al., supra note 3; Mitchell et al., supra note 7; Gornick et al., supra note 7; Wallace, supra note 6.

[FN285]. Sullivan, *Study Charges Bias*, supra note 14, at 127; Sullivan, *New Rules Sought*, supra note 14, at 146.

[FN286]. See N.Y. State Advisory Comm., *Minority Elderly Access*, supra note 6, at ii-iii (transmittal letter).

[FN287]. U.S. Comm'n on Civil Rights, *Federal Title VI Enforcement* (1996), supra note 8, at 1-2.

[FN288]. *Alexander v. Sandoval*, 532 U.S. 275 (2001).

[FN289]. 42 U.S.C. § 1481 (2000).

[FN290]. U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 24.

[FN291]. *Id.* at 1.

[FN292]. 42 U.S.C. § 2000d.

[FN293]. U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 3.

[FN294]. *Id.*

[FN295]. See Smith, *supra* note 55, at 159-64, 236-52.

[FN296]. See Grabowski, *supra* note 3, at 456; Mor et al., *supra* note 3, at 237; Fennell et al., *supra* note 3, at 174; Falcone & Broyles, *supra* note 3, at 591-93; Smith, *supra* note 3, at 857, 860-61; N.Y. State Advisory Comm., Minority Elderly Access, *supra* note 6; Wallace, *supra* note 6, at 677; Weissert & Cready, *supra* note 3, at 619, 642, 645.

[FN297]. *Alexander v. Sandoval*, 532 U.S. 275, 295 (2001) (Stevens, J., dissenting).

[FN298]. Marianne Engelman Lado, Unfinished Agenda: The Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery, 6 Tex. F. on C.L. & C.R. 28 (2001) (citing Michael Meltsner, *Equality and Health*, 115 U. Pa. L. Rev. 22, 22 (1966)).

[FN299]. Both Congress and HHS are responsible for granting funding to OCR. The literature tends to show that when provided with ample funding HHS still cut back on OCR's funding. See Smith, *supra* note 55, at 100-02.

[FN300]. U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 218.

[FN301]. *Id.*

[FN302]. *Id.* at 222.

[FN303]. Smith, *supra* note 26, at 87; see U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 223.

[FN304]. Smith, *supra* note 26, at 86. Most divisions of HHS regulating operating programs thought of OCR as a nuisance. *Id.* at 87.

[FN305]. In 1977, the Centers for Medicare & Medicaid Services ("CMS"), formerly known as the Health Care Financing Administration ("HCFA"), was created to administer and regulate Medicare. See Pub. L. No. 95-135, 91 Stat. 1166 (1977); 66 Fed. Reg. 35, 437-503 (July 5, 2001). To prevent any confusion, this article solely refers to the agency as CMS.

[FN306]. U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 220.

[FN307]. *Id.* at 226. OCR has no authority to review health care facilities seeking participation in Medicaid pre or post award. *Id.* at 221. States handle the pre- and postaward review of Medicaid certified nursing homes. *Id.* at 226.

[FN308]. *Id.* at 227.

[FN309]. *Id.* at 220-21.

[FN310]. *Id.* at 226-27.

[FN311]. *Id.* at 220-21.

[FN312]. Smith, *supra* note 26, at 87.

[FN313]. *Id.*

[FN314]. See U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 232.

[FN315]. See *id.*

[FN316]. See *id.*

[FN317]. Lado, *supra* note 298, at 29-30 (citing House Comm. on Gov't Operations, Investigation of the Office for Civil Rights in the Dep't of Health and Human Servs., H.R. Rep. No. 100-56, at 14, 22-25 (1987)).

[FN318]. *Id.* at 29.

[FN319]. *Id.* at 29-30.

[FN320]. See Civil Rights Act of 1964, [42 U.S.C. § 2000d-1 \(2000\)](#).

[FN321]. Lado, *supra* note 298, at 29-30 (citing House Comm. on Gov't Operations, Investigation of the Office for Civil Rights in the Dep't of Health and Human Servs., H.R. Rep. No. 100-56, at 14, 22-25).

[FN322]. *Id.* at 31-33; see also U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 230.

[FN323]. U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 230-31.

[FN324]. See *id.*; see also U.S. Comm'n on Civil Rights, Funding Federal Civil Rights Enforcement, *supra* note 36, at 22.

[FN325]. U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 231.

[FN326]. *Id.* at 226-28.

[FN327]. See *id.* at 227-28.

[FN328]. *Id.* at 233-34; Smith, *supra* note 26, at 92.

[FN329]. U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 233.

[FN330]. *Id.* at 234.

[FN331]. *Id.* You can also attribute the statement to plaintiffs' argument in a complaint against HHS, that the agency could not effectively enforce Title VI because it failed to publish measures of the racial integration of health care providers, produce routine reports on the ethnic distribution of recipients by health care providers, require uniform race or ethnic data collection or reporting from health care providers. See [Madison-Hughes v.](#)

Shalala, 80 F.3d 1121, 1123 (6th Cir. 1996)

[FN332]. See U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 234.

[FN333]. See *id.* at 233-34.

[FN334]. Smith, *supra* note 26, at 87.

[FN335]. See OCR Press Releases 1997-2003, <http://www.hhs.gov/ocr/newspg.html> (last visited Jan. 18, 2007); see also OCR What's New Items 2000-2006, <http://www.hhs.gov/ocr/whatsnew.html> (last visited Jan. 18, 2007). Interviews with Region V OCR employees (Apr. 13, 2001, Mar. 5, 2005 & Aug. 24, 2006).

[FN336]. See Civil Rights Act of 1964, 42 U.S.C. § 2000d-1 (2000).

[FN337]. U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 233-34.

[FN338]. See *id.*

[FN339]. *Id.* at 230-31. In 1996, OCR's goal was to implement "'uniformly strong remedies' to civil rights violations 'to make injured parties whole, lessen the chance of future violations, and set a clear precedent for other parties.'" *Id.* at 231. To date none of this has occurred.

[FN340]. See *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001).

[FN341]. See generally *id.*

[FN342]. Mor et al., *supra* note 3, at 237; Grabowski, *supra* note 3, at 456; Fennell et al., *supra* note 3, at 174; Falcone & Broyles, *supra* note 3, at 591-93; Smith, *supra* note 3, at 857, 860, 861; N.Y. State Advisory Comm., Minority Elderly Access, *supra* note 6, at 3-4; Wallace, *supra* note 6, at 677; Weissert & Cready, *supra* note 3, at 642, 645.

[FN343]. *Taylor v. White*, 132 F.R.D. 636 (E.D. Pa. 1990); *Linton ex rel. Arnold v. Comm'r of Health & Env't*, 779 F. Supp. 925 (M.D. Tenn. 1990).

[FN344]. 779 F. Supp. 925 (M.D. Tenn. 1989).

[FN345]. 132 F.R.D. 636 (E.D. Pa. 1990).

[FN346]. *Id.* at 639; *Linton*, 779 F. Supp. at 927-29.

[FN347]. *Linton*, 779 F. Supp. at 928-29.

[FN348]. *Id.* at 928-29, 932.

[FN349]. 532 U.S. 275 (2001).

[FN350]. *Id.* at 279.

[FN351]. *Id.*

[FN352]. *Id.* at 278.

[FN353]. See *id.* at 279.

[FN354]. *Id.* at 278-79. The argument that making English the official language of the state was not intentional racism is a weak argument. There are no reasons other than discrimination to sustain the enactment of an English-only law.

[FN355]. *Id.* at 279.

[FN356]. *Id.* at 285.

[FN357]. *Id.* at 284-85.

[FN358]. See, e.g., 45 C.F.R. § 80 (noting statutory authority arises from section 602 of Title VI); 45 C.F.R. § 80.3(b)(2) (2005).

[FN359]. *Sandoval*, 532 U.S. at 285-88.

[FN360]. This is one of Justice Stevens's major points in his dissent. *Id.* at 313-17 (Stevens, J., dissenting). The distinction was made in a civil rights case involving Title VII and applied to all civil rights litigation. See Smith, *supra* note 26, at 90 (citing *Griggs v. Duke Power Co.*, 401 U.S. 424 (1971)).

[FN361]. Smith, *supra* note 26, at 90.

[FN362]. See *Guardians Ass'n v. Civil Serv. Comm'n of New York*, 463 U.S. 582 (1983); *Cannon v. Univ. of Chicago*, 441 U.S. 677 (1979); *Lau v. Nichols*, 414 U.S. 563 (1974).

[FN363]. See *Sandoval*, 532 U.S. at 294 (Stevens, J., dissenting).

[FN364]. See *id.* at 294-95.

[FN365]. *Id.* at 278 (majority opinion); Rosenbaum & Teitelbaum, *supra* note 44, at 241.

[FN366]. Smith, *supra* note 55, at 100-02.

[FN367]. See *id.*

[FN368]. *Id.*

[FN369]. 532 U.S. 275 (2001).

[FN370]. See *id.* at 278-79.

[FN371]. Fennell et al., *supra* note 3, at 174; Falcone & Broyles, *supra* note 3, at 588-92; Smith, *supra* note 3, at 852; Weissert & Cready, *supra* note 3, at 642, 645.

[FN372]. U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 1-5; U.S. Comm'n on Civil Rights, Federal Title VI Enforcement to Ensure Nondiscrimination in Federally Assisted Programs 15 (1995) [hereinafter U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1995)]; N.Y. State Advisory Comm., Minority Elderly Access, *supra* note 6, at ii-iii (transmittal letter); N.Y. State Advisory Comm., Minority Elderly Access, *supra* note 6, at 37-38 (citing Jeffrey Amber, Executive Director of Friends and Relatives of the Institutionalized Aging); U.S. Comm'n on Civil Rights, The Federal Civil Rights Enforcement Effort Seven

Months Later 3-5 (1971) [hereinafter U.S. Comm'n on Civil Rights, Civil Rights Enforcement Effort].

[FN373]. See generally Mor et al., *supra* note 3; Grabowski, *supra* note 3; Howard et al., *supra* note 7; Levine et al., *supra* note 7; Fennell et al., *supra* note 3; Mitchell et al., *supra* note 7; Gornick, *supra* note 7; Wallace, *supra* note 6.

[FN374]. U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 3-5; U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1995), *supra* note 372, at 15; U.S. Comm'n on Civil Rights, Civil Rights Enforcement Effort, *supra* note 372, at 1-5.

[FN375]. U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 1-5; U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1995), *supra* note 372, at 15; U.S. Comm'n on Civil Rights, Civil Rights Enforcement Effort, *supra* note 372, at 3-7.

[FN376]. 80 F.3d 1121 (6th Cir. 1996).

[FN377]. *Id.* at 1123. Ironically, HHS, the federal agency charged with enforcing Title VI in health care, argued that it had no legal duty to collect this information, but provides thousands of dollars in grants to researchers to collect the same data, which it does nothing with other than publish it in medical journals. See *id.* at 1130-31.

[FN378]. *Id.* at 1125.

[FN379]. *Id.*

[FN380]. *Id.* at 1127-28.

[FN381]. *Id.* at 1128.

[FN382]. See Lado, *supra* note 298, at 26-33 (citing House Comm. on Gov't Operations, Investigation of the Office for Civil Rights in the Department of Health and Human Services, H.R. Rep. No. 100-56 at 14, 22-25 (1987)). See also U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 230; U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1995), *supra* note 372, at 22.

[FN383]. The author is currently working on an article further discussing the effectiveness of this state-based solution, including an empirical study that strongly suggests the unrestricted continuation of racial discrimination in nursing homes in Illinois.

[FN384]. *Estate of Smith v. Heckler*, 747 F.2d 583, 585 (10th Cir. 1984).

[FN385]. For further discussion, see Vernellia Randall, Eliminating Racial Discrimination in Health Care: A Call for State Health Care Anti-Discrimination Law, in *Dying While Black* 93 (2006).

[FN386]. See Yearby, *supra* note 52, at 973, for a detailed discussion of the application of CERD to racial discrimination in nursing homes. See generally, Vernellia R. Randall, [Racial Discrimination in Health Care in the United States as a Violation of the International Convention on the Elimination of All Forms of Racial Discrimination](#), 14 U. Fla. J.L. & Pub. Pol'y 45, 47-65 (2002).

[FN387]. There are two types of suits that can be brought under Medicaid: bias and poor quality. In the 1970s and 1980s, elderly African Americans brought lawsuits in Tennessee and Pennsylvania against the government regarding nursing homes' use of Medicaid to racially discriminate against African Americans. See [Taylor v.](#)

[White](#), 132 F.R.D. 636 (E.D. Pa. 1990). The lawsuits asserted that the states' Medicaid bed certification policy allowed nursing homes to deny African American Medicaid patients admission because the nursing home did not have any Medicaid beds, but if a White Medicaid patient sought admission then another Medicaid bed would be certified. Thus, nursing homes used Medicaid as a proxy to deny African Americans admission based on neutral policies in violation of Title VI. Private parties' legal rights to bring disparate impact claims under Title VI was eviscerated by the Supreme Court in [Alexander v. Sandoval](#), 532 U.S. 275 (2001). Because in the past Medicaid bias claims used the theory of disparate impact to racial discrimination, it is unclear whether private parties can file Medicaid bias claims against the government to address racial discrimination in health care. Therefore, this article will only discuss the government's failure to provide quality health care as required under the Medicaid Act.

[FN388]. See Social Security Act, 42 U.S.C. § 1395b(g)(3) (2000).

[FN389]. See Fennell et al., *supra* note 3, at 174; Falcone & Broyles, *supra* note 3, at 588-92; Smith, *supra* note 3, at 852; Weissert & Cready, *supra* note 3, at 642, 645.

[FN390]. 747 F.2d 583, 591 (10th Cir. 1984).

[FN391]. *Id.* The plaintiffs brought this action under 42 U.S.C. § 1983, seeking remedies for alleged violations of their constitutional right to receive quality care in nursing homes certified to participate in the Medicaid program. [Estate of Smith v. O'Halloran](#), 557 F. Supp. 289, 290 (D. Colo. 1983). The plaintiffs lost in district court, but prevailed on appeal. *Id.* at 299. The case was originally filed in the United States District Court for the District of Colorado on May 16, 1975, but did not go to trial until May 17, 1982. *Id.* at 292. The defendants in the suit included the Secretary, all nursing home owners and administrators of Medicaid certified nursing homes in Colorado, and the officers of the Colorado Department of Social Services and the Colorado Department of Health. *Id.* at 290. The state officials were dropped from the suit in exchange for their stipulation that the State would file a complaint against the Secretary seeking a revision of the Medicaid nursing home enforcement system. *Id.* at 290-91. Pursuant to the stipulation of dismissal, the Colorado Attorney General filed a suit against the Secretary seeking declaratory and injunctive relief for the Secretary's alleged failure to fulfill the mandate of the Social Security Act of 1935 by not effectively regulating Medicaid nursing homes. *Id.* at 291.

[FN392]. Although the States administer the Medicaid program, the Plaintiffs argued that the Secretary had a duty to regulate Colorado's Medicaid plan based on the powers Congress granted the Secretary under Medicaid. *Id.* at 295.

[FN393]. *Id.* at 291-92.

[FN394]. *Id.* at 295.

[FN395]. See [Harris v. McRae](#), 448 U.S. 297, 308-09 (1980).

[FN396]. See Social Security Act, 42 U.S.C. §§ 1395x(j), 1396a(a)(22), 1396a(a)(28) (2000).

[FN397]. See *id.* § 1396a(b). This “look behind” provision was passed as part of the Omnibus Reconciliation Act of 1980, the same bill that created alternative sanctions to the termination of long-term care facilities. See Pub. L. No. 96-499, § 916, 94 Stat. 2599 (1980).

[FN398]. See Social Security Act, § 1396b(g)(1).

[FN399]. See [Heckler](#), 747 F.2d at 591.

[FN400]. Id.

[FN401]. Id. at 590 (alteration in original) (quoting [H.R. Rep. No. 96-1167](#), at 57 (1980), reprinted in 1980 U.S.C.C.A.N. 5526, 5570-71).

[FN402]. Id. See also [H.R. Rep. No. 96-1479](#), at 140-41 (1980) (Conf. Rep.), reprinted in 1980 U.S.C.C.A.N. 5903, 5931-32.

[FN403]. [H.R. Rep. No. 96-1479](#), at 141 (1980) (Conf. Rep.), reprinted in 1980 U.S.C.C.A.N. 5903, 5932.

[FN404]. [Heckler](#), 747 F.2d at 591-92. On June 10, 1985, the United States District Court for the District of Colorado ordered the Secretary to promulgate new regulations consistent with the Court of Appeals mandate. See [HHS Plan of Compliance with Court Order at *1](#), [Smith v. Heckler](#), No. 75-M-539 (D. Colo. June 10, 1985), 1985 WL 56558. Nevertheless, the Secretary failed to meet all the objectives of the order and was ordered to revise its regulations and finally found in contempt of the order in 1987. See generally [Estate of Smith v. Bowen](#), 656 F. Supp. 1093 (D. Colo. 1987); see also [Estate of Smith v. Bowen](#), 675 F. Supp. 586 (D. Colo. 1987). In 1988, the Secretary submitted the passage of the Nursing Home Reform Act as means of compliance, but the court ruled that, “[t]he passage of the OBRA [of 1987] in no way modifies or preempts the Tenth Circuit's decision.” [Smith v. Bowen](#), No. 75-M-539, 1988 WL 235574, at *1 (D. Colo. Feb. 18, 1988). In June, the Secretary finally enacted regulations in compliance with the court's order, amending both the Medicaid and Medicare regulations. See [53 Fed. Reg. 22850-01](#) (June 17, 1988).

[FN405]. See [Estate of Smith v. Heckler](#), 747 F.2d 583 (10th Cir. 1984).

[FN406]. See Social Security Act, 42 U.S.C. § 1396a(a)(9)(A) (2000).

[FN407]. IOM Report, *supra* note 63, at 15-16.

[FN408]. See generally [Fennell et al.](#), *supra* note 3.

[FN409]. Id. at 174.

[FN410]. Id. at 178-79.

[FN411]. See generally [Grabowski](#), *supra* note 3; [Mor et al.](#), *supra* note 3.

[FN412]. [Grabowski](#), *supra* note 3, at 456.

[FN413]. 747 F.2d 583 (10th Cir. 1984).

[FN414]. 779 F. Supp. 925 (M.D. Tenn. 1989).

[FN415]. 132 F.R.D. 636 (E.D. Pa. 1990).

[FN416]. See Fair Housing Act, 42 U.S.C. § 3604(a), (c), (d) (2000).

[FN417]. See [Smith](#), *supra* note 55, at 159-63, 236-52.

[FN418]. See *id.* at 236-38.

[FN419]. See *id.* at 159-60.

[FN420]. This solution will be discussed in greater detail in a forthcoming article by the author. The article will address the issue of whether the nursing home is acting as a private party, and thus not subject to the regulation of the Fair Housing Act, as well as whether parties can bring both a Title VI and Title VIII claim.

[FN421]. See Fair Housing Act, § 3604(a), (c), (d).

[FN422]. See *Trifficante v. Metro. Life Ins. Co.*, 409 U.S. 205, 207-08 (1972).

[FN423]. See Trial Brief of United States, *supra* note 1, at 15 (citing *Asbury v. Brougham*, 866 F.2d 1276, 1280-81 (10th Cir. 1989)).

[FN424]. *Selden Apartments v. U.S. Dep't of Hous. & Urban Dev.*, 785 F.2d 152, 159 (6th Cir. 1986).

[FN425]. See generally Fair Housing Act, § 3612. Elderly African Americans denied admission to nursing homes because of race can also use section 3604(a) of the Fair Housing Act to initiate private actions against the perpetrating nursing homes. See *id.* § 3613. Elderly African Americans could successfully bring a claim under the Fair Housing Act if they could show that Whites were admitted after they were denied. This should be easy as the data discussed in Section IV shows that some nursing homes deny African Americans and then admit Whites. Specifically, data shows that some nursing homes use avoidance techniques to deny elderly African Americans admission to quality nursing homes. In two different studies of North Carolina nursing homes, researchers showed that elderly African Americans were delayed in accessing medically necessary services because of their race. Falcone & Broyles, *supra* note 3, at 588-92; Weissert & Cready, *supra* note 3, at 632, 642. In both studies, the researchers found that the nursing homes denied admission to African Americans based on the racially discriminatory preferences of their current patients and prospective patients. *Id.* African Americans who have been denied access to nursing homes remain in the hospital and incur unnecessary costs. The strength of using housing claims to address racial discrimination in health care is that aggrieved parties could obtain actual and punitive damages. It would also be a way to re-create a private right of action to sue for disparate impact under the Fair Housing Act that was lost under Title VI. Some weaknesses of this solution include the failure to address quality of care problems. These actions will not address the poor quality of care provided by nursing homes where African Americans are currently relegated; only a Medicaid or Title VI action would address this issue. Furthermore, housing discrimination suits tend to be costly, unsuccessful campaigns to change the behavior of landlords. However, these suits offer elderly African Americans another weapon against the offense of racial discrimination.

[FN426]. See Fair Housing Act, § 3608(c).

[FN427]. See *id.* § 3612(g)(3)(A)-(C).

[FN428]. OIG External Audit Reports--by State, in Date Sequence, <http://www.hud.gov/offices/oig/reports/oigstate.cfm> (last visited Nov. 13, 2006).

[FN429]. *United States v. Lorantffy Care Ctr.*, 999 F. Supp. 1037 (N.D. Ohio 1998). A Westlaw search of the Fair Housing Act and nursing homes showed that nine other cases were reported, but those cases dealt with issues concerning discrimination against the disabled.

[FN430]. *Id.* at 1040.

[FN431]. *Id.* at 1041; see also Order of Judge Sam Bell, *United States v. Lorantffy Care Ctr.*, 999 F. Supp. 1037 (N.D. Ohio 1998) (No. 97-CV-00295).

[FN432]. See Trial Brief of United States, *supra* note 1, at 15-18.

[FN433]. *Id.* at 3-11.

[FN434]. *Id.*

[FN435]. *Id.* at 3.

[FN436]. *Id.* at 14, 16.

[FN437]. See Trial Brief of Lorantffy Care Center, *supra* note 2, at 8-13. The nursing home presented a host of defenses such as questioning the veracity of the government's witnesses and the fact that they had admitted three African Americans in their twenty-four year history. *Id.* at 5. Because a jury decided the case, it is unclear what evidence or defense was relevant in its decision. The Author has chosen to present the most relevant defenses to the presentation of the tester evidence. A full discussion of this case will be addressed in another article reviewing the use of the Fair Housing Act to rectify housing discrimination in health care.

[FN438]. See *id.* at 3-4.

[FN439]. See *id.* at 4-5.

[FN440]. See *id.* at 5.

[FN441]. *Id.* at 11-12.

[FN442]. See *id.* at 12.

[FN443]. See Order of Judge Sam Bell, *supra* note 431.

[FN444]. See Williams, Racial Residential Segregation, *supra* note 28, at 404-07; Williams, Race, Socioeconomic Status, and Health, *supra* note 28, at 177-78. Furthermore, general studies of Professors Frances Fox Piven and Richard Cloward “explained high rates of poverty among African Americans as the result of institutional racism, which refers to the systematic differential allocation of rewards based on race.” Angel & Angel, *supra* note 28, at 1154 (citing Frances Fox Piven & Richard Cloward, *The New Class War* (Pantheon Books 1985)). Professors Jacqueline Angel and Ronald Angel further noted that, “[H]istorically, African Americans and Hispanics have been disproportionately confined to the low-wage service sector or to casual and informal jobs, where payment is made in cash and where their ability to accumulate wealth is impaired.” *Id.* This “[i]nstitutional racism and discrimination perpetuate poverty and its resultant individual-level health damage through unsafe and unhealthful environments, low educational levels, inadequate medical care, and feelings of helplessness and hopelessness.” *Id.* (citing David Williams, *Racism and Health: A Research Agenda*, 6 *Ethnicity and Disease* 1, 3 (1996)).

[FN445]. Derrick Bell, *Brown v. Board of Education: Reliving and Learning from Our Racial History*, 66 *U. Pitt. L. Rev.* 21, 25 (2004).

[FN446]. International Convention on the Elimination of All Forms of Racial Discrimination art. 4(b), opened for signature Dec. 21, 1965, 660 U.N.T.S. 195 (entered into force Jan. 4, 1969) [hereinafter Convention on Elim-

ination of Racial Discrimination].

[FN447]. *Id.* at art. 2(1).

[FN448]. *Id.* at art. 2(1)(c).

[FN449]. *Id.* at art. 14(1) (noting private parties can complain directly to the Committee if their state has recognized the competence of the Committee to hear such communications).

[FN450]. *Id.* at art. 6.

[FN451]. 140 Cong. Rec. S7634-02 (1994). By signing the CERD, the United States indicated its intention to be bound by the CERD and creating an obligation to refrain in good faith from acts that would defeat the object and purpose of the treaty. Although the CERD is not self-executing, and thus arguably cannot be used in U.S. courts, this does not limit its use by the Committee or International Court of Justice. See U.N. High Comm'n for Human Rights, *supra* note 446, at art. 14.

[FN452]. See Convention on Elimination of Racial Discrimination, *supra* note 446, art. 2. In ratifying the CERD, the United States Senate noted that “the Constitution and laws of the United States establish extensive protections against discrimination, reaching significant areas of non-governmental conduct,” but this authority did not extend to private conduct. 140 Cong. Rec. S7634-02 (1994). Thus, the United States authority over “public institutions” to prevent discrimination was limited to the regulation “of public conduct that is customarily the subject of government regulation.” *Id.*

[FN453]. See Convention on Elimination of Racial Discrimination, *supra* note 446, art. 5(e)(iv).

[FN454]. See Civil Rights Act of 1964, 42 U.S.C. § 2000(d) (2000).

[FN455]. See *id.*; see also Convention on Elimination of Racial Discrimination, *supra* note 446, art. 5.

[FN456]. U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 1-5; U.S. Comm'n on Civil Rights, Civil Rights Enforcement Effort, *supra* note 372, at 3-7.

[FN457]. Weinick et al., *supra* note 17, at 36-37.

[FN458]. Mor et al., *supra* note 3, at 228; Grabowski, *supra* note 3, at 456; Fennell et al., *supra* note 3, at 174; Falcone & Broyles, *supra* note 3, at 591-93; Smith, *supra* note 3, at 857, 862-63; N.Y. State Advisory Comm., Minority Elderly Access, *supra* note 6, at 2; Wallace, *supra* note 6, at 677; Weissert & Cready, *supra* note 3, at 642, 645.

[FN459]. Mor et al., *supra* note 3, at 228; Grabowski, *supra* note 3, at 456; Fennell et al., *supra* note 3, at 174; Falcone & Broyles, *supra* note 3, at 591-93; Smith, *supra* note 3, at 857, 862-63; N.Y. State Advisory Comm., Minority Elderly Access, *supra* note 6, at 2; Wallace, *supra* note 6, at 677; Weissert & Cready, *supra* note 3, at 642, 645.

[FN460]. U.S. Comm'n on Civil Rights, Federal Title VI Enforcement (1996), *supra* note 8, at 230-31.

[FN461]. See generally *id.*

[FN462]. See *Taylor v. White*, 132 F.R.D. 636 (E.D. Pa. 1990); *Linton ex rel. Arnold v. Comm'r of Health &*

Env't, 779 F. Supp. 925 (M.D. Tenn. 1990).

[FN463]. 532 U.S. 275 (2001).

[FN464]. *Id.* at 293.

[FN465]. Linton, 779 F. Supp. at 936.

[FN466]. Falcone & Broyles, *supra* note 3, at 592-93.
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