

2010

African Americans Can't Win, Break Even, or Get Out of the System: The Persistence of "Unequal Treatment" in Nursing Home Care

Ruqaiijah A. Yearby

Saint Louis University School of Law

Follow this and additional works at: <https://scholarship.law.slu.edu/faculty>

 Part of the [Civil Rights and Discrimination Commons](#), [Health Law and Policy Commons](#), and the [Medical Jurisprudence Commons](#)

Recommended Citation

Yearby, Ruqaiijah A., "African Americans Can't Win, Break Even, or Get Out of the System: The Persistence of "Unequal Treatment" in Nursing Home Care" (2010). *All Faculty Scholarship*. 87.

<https://scholarship.law.slu.edu/faculty/87>

This Article is brought to you for free and open access by Scholarship Commons. It has been accepted for inclusion in All Faculty Scholarship by an authorized administrator of Scholarship Commons. For more information, please contact erika.cohn@slu.edu, ingah.daviscrawford@slu.edu.

C

Temple Law Review
Spring-Summer 2010

Article

***1177 AFRICAN AMERICANS CAN'T WIN, BREAK EVEN, OR GET OUT OF THE SYSTEM: THE PERSISTENCE OF "UNEQUAL TREATMENT" IN NURSING HOME CARE**

Ruqaijah Yearby [FN1]

Copyright (c) 2010 Temple University of the Commonwealth System of Higher Education;
Ruqaijah Yearby

I. Introduction

Bennie Saxon had dementia. Because his family could not care for him at home, he was placed at Alden Wentworth Rehabilitation and Health Care Center ("Alden Wentworth"), a predominately African American nursing home in Chicago, Illinois. On May 4, 2009, he fell four stories to his death. The Cook County Office of the Medical Examiner ruled Mr. Saxon's fall an accident, but his family alleges that his death was caused by neglect. This was not the first incident at this nursing home.

Between 2004 and 2009, thirteen civil cases were filed against Alden Wentworth, more than three times the lawsuits filed against half of the city's ninety-one nursing homes. In fact three years prior to Mr. Saxon's death, the nursing home settled a case for the death of Bernetta Hall, a disabled forty-six-year-old woman. Mrs. Hall entered Alden with a single pressure sore at the base of her spine; however, after just five weeks, "she developed sores on her heels, buttock and ear because of the poor care she received at the home," which contributed to her death. [FN1]

Alden Wentworth, a predominately African American nursing home, is part of a chain of thirty for-profit nursing homes throughout Illinois, among which are three predominately African American nursing homes and sixteen predominately Caucasian nursing homes. [FN2] All three of the predominately African American nursing homes received the lowest quality ranking by the federal government, whereas fewer than half of the sixteen predominately Caucasian facilities received that same rating. [FN3] In fact, the two nursing homes that received the highest quality ratings were predominately *1178 Caucasian. [FN4] However, a 2009 investigation by the Chicago Reporter ("Reporter") showed that Alden Wentworth "has the worst rating a nursing home can get--three times the number of lawsuits of half of Chicago nursing homes--and that residents get less than half the time each day with staff than residents at a predominantly white facility in Evanston operated by the same owner." [FN5]

Empirical data show that racial disparities in the quality of care provided by nursing

homes are a common occurrence, not isolated to Illinois. [FN6] Nine years after the publication of the groundbreaking Institute of Medicine Study (“IOM study”) *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, [FN7] which acknowledged continued racial disparities in health care and provided suggestions for the elimination of these disparities, racial disparities still remain. One chief example of the continuation of racial disparities in health care is in the provision of nursing home care. [FN8]

Decades of empirical research studies have shown that racial disparities in accessing quality nursing home care continue to exist, particularly between African Americans and Caucasians. [FN9] In the 1980s and 1990s, empirical studies showed that ***1179** elderly African Americans had difficulty in obtaining access to nursing home care. Specifically, research conducted in New York and North Carolina revealed that African Americans experienced delays in transfers to nursing homes because they were denied admission to nursing homes based on their race. [FN10] Since these studies, elderly African Americans have been using nursing homes more than Caucasians; however, African Americans have been relegated to racially segregated nursing homes. [FN11]

Moreover, ten years of research show that African Americans disproportionately reside in substandard nursing homes compared to Caucasians. [FN12] For instance, empirical data from several states, including New York, North Carolina, and Illinois, show that race remains the greatest predictor of the provision of poor-quality nursing home care. [FN13] The persistence of racial disparities in the provision of quality nursing home care is significant because a considerable number of elderly African Americans will need access to quality nursing home care within the next twenty years.

***1180** It is predicted that the use of long-term care services, [FN14] such as nursing homes, will increase from eight million in 2000 to nineteen million in 2050. [FN15] Since 1995, the population of African Americans residing in nursing homes has been greater than the Caucasian population, and this usage pattern is expected to continue. [FN16] Because the increase in nursing home use will be by elderly African Americans, and African Americans disproportionately reside in poor quality nursing homes, there is great urgency in putting an end to racial disparities in the provision of quality nursing home care.

Overall, a review of the empirical data provides a dismal picture of the accessibility of quality nursing home care available to elderly African Americans. Therefore, it is important to identify the causes of the problem. Some scholars have asserted that socioeconomic status and residential segregation explain why racial disparities in nursing homes persist, while others have submitted that racial bias is the culprit. [FN17] I suggest that these reasons are inextricably intertwined.

Racial bias operates on three different levels in health care: structural, institutional, and interpersonal. [FN18] Structural bias in health care allows those with privilege, such as wealthy Caucasians, to obtain the best quality nursing home care available. [FN19] Those without privilege, such as the poor and minorities, are relegated to poor quality nursing homes. The institutional structures of nursing home regulation, such as the lack of certificate-of-need programs, allows nursing home owners to leave predominately poor and minority

neighborhoods devoid of health care services to relocate to over-serviced affluent areas. [FN20] Health care providers' conscious and unconscious racial bias used to determine who is admitted to the nursing home based on race illustrates interpersonal discrimination. [FN21] Even though evidence shows that ***1181** racial bias is the central reason for racial disparities in the provision of quality nursing home care, the nursing home regulatory system does not consider racial bias when regulating the quality of nursing home care. [FN22] Instead of addressing the root cause of quality problems in predominately African American nursing homes, regulators just evaluate the effects: poor quality. Furthermore, structural, institutional, and interpersonal racial bias are present in the nursing home regulatory system, leaving African Americans without protection or exacerbating the disparities in quality. One example of these problems is the federal government's nursing home quality improvement program, the Special Facility Focus Initiative ("SFF Initiative"). [FN23]

In 1998, the Centers for Medicare and Medicaid Services ("CMS"), an agency in the U.S. Department of Health and Human Services ("HHS"), [FN24] initiated the SFF Initiative, a quality improvement program for substandard nursing homes. Under the SFF Initiative, states are required to visit nursing homes designated as special focus facilities usually twice a year to ascertain the quality of care provided residents. [FN25] If the quality in the nursing homes does not improve after three visits or within 18 months, CMS may involuntarily terminate the nursing home from the Medicare and/or Medicaid programs. [FN26] Notably, most poor quality nursing homes that are predominately African American are rarely in this program, [FN27] even though evidence shows that these nursing homes tend to provide worse care than predominately Caucasian nursing homes. [FN28] The poor quality predominately African American nursing homes on the list remain on the list longer than 18 months and do not improve enough to be removed from the list. [FN29]

***1182** Using the problems with the long-term care system as a case study, this Article highlights the fact that racial disparities persist in health care because of racial bias. Section II reviews empirical data illustrating the continuation of racial disparities in accessing nursing home care to explain why African Americans cannot win. Showing why African Americans cannot break even, Section III analyzes research revealing racial disparities in the provision of quality nursing home care. Demonstrating why African Americans cannot get out of the system, Section IV discusses the increased disability of African Americans that forces them to seek medical care from nursing homes, even though the care provided is substandard. Section V discusses the causes of these racial disparities in the provision of quality nursing home care. Finally, Section VI discusses the failures of race-neutral policies to address the root causes of racial disparities.

II. African Americans Can't Win: Racial Disparities in Accessing Nursing Home Care

Nursing homes are the central institutional provider of care for the elderly. [FN30] In the 1980s and 1990s, more Caucasians used nursing homes than African Americans, and research showed that African Americans were denied access to nursing homes because of their race. [FN31] For instance, in 1984, a study of New York nursing homes showed that nursing homes that provided excellent quality of care demonstrated a pattern of admitting Caucasians over

African Americans. [FN32] The study was based on civil rights documents submitted by nursing homes to the New York State Health Department. [FN33]

Almost a decade later, in 1992, the New York State Advisory Committee to the U.S. Commission on Civil Rights (“Advisory Committee”) reported that there were still significant racial inequities in nursing home admissions between African Americans and Caucasians. [FN34] The Advisory Committee's findings showed that Caucasian patients were three times more likely to get into a quality nursing home than minority patients. According to the report, Caucasian patients were admitted to quality nursing homes while racial minorities were relegated to substandard quality nursing *1183 homes. [FN35] This racial segregation in nursing homes persists even though African Americans' use of nursing homes is greater than Caucasians' use.

In 2004, nursing homes provided care to 1.5 million elderly and disabled persons, with the average length of stay being 835 days. [FN36] By 2050, nursing homes are projected to provide care to 6.6 million elderly and disabled persons. [FN37] By 2004, African Americans' use of nursing homes was thirty-two percent higher than Caucasians' use. [FN38] Yet, two-thirds of all African American nursing home residents reside in just ten percent of all facilities. [FN39]

A 2007 national study of nursing homes found that the nursing homes that house African Americans tend to be racially segregated. [FN40] As a result of the concentration of African Americans in a small number of nursing homes, these facilities are often designated as predominately African American facilities. [FN41] Thus, even with increased use of nursing homes, African Americans still cannot win equal access to nursing home care.

Denied access to diverse nursing homes, African Americans are relegated to racially segregated poorly performing nursing homes. These nursing homes not only cause African Americans to suffer harm, [FN42] but the government also rates them poorly. [FN43]

III. African Americans Can't Break Even: The Provision of Quality Nursing Home Care

The Medicare [FN44] and Medicaid [FN45] Acts require the federal government to ensure that those residing in nursing homes are provided quality nursing home care. [FN46] As the data *1184 shows, a majority of elderly African Americans reside in poor quality nursing homes compared to Caucasians. [FN47] Thus, in spite of the passage of the quality requirements under the Medicare and Medicaid Acts, African Americans cannot break even because they are relegated to substandard nursing homes.

A. Surveying the Quality of Care in Nursing Homes

The U.S. Department of Health and Human Services (“HHS”) is the federal agency in charge of regulating the quality of care provided by nursing homes that receive funding from the Medicare and/or Medicaid programs. [FN48] HHS delegated its duties to the Centers for Medicare and Medicaid Services (“CMS”) and the states. CMS has sole authority under the

Medicare Act [FN49] and shares the responsibility with the states under the Medicaid Act. [FN50] Once a nursing home is certified to participate in the Medicare and/or Medicaid program, either CMS or the state conducts an annual recertification inspection every nine to fifteen months. [FN51] This recertification process is called “survey and certification.” [FN52] Regardless of who conducts the survey, the team is comprised of, among others, nurses, nutritionists, social workers, and physical therapists. [FN53] The certification team assesses whether the nursing home continues to be in compliance with the Medicare and/or Medicaid conditions of participation. [FN54]

***1185** The purpose of the conditions of participation is to ensure that residents of nursing homes receive quality physical and mental care by establishing participation standards to protect the patient's rights and health status. [FN55] Nursing homes certified to participate in the Medicare and Medicaid programs are required to fulfill the conditions of participation for all residents, regardless of the race or payment status of the resident. [FN56]

State surveyors use fifteen conditions of participation to review the compliance of nursing homes with the Medicare and Medicaid Act. [FN57] These conditions include: resident rights, [FN58] resident behavior, [FN59] quality of life, [FN60] resident assessment, [FN61] quality of care, [FN62] nursing services, [FN63] dietary services, [FN64] physician services, [FN65] rehabilitative services, [FN66] dental services, [FN67] pharmacy services, [FN68] infection control, [FN69] administration, [FN70] admission and transfer rights, [FN71] and physical environment. [FN72]

A nursing home is required to complete a resident assessment instrument for all patients upon admission and whenever there is a significant change in the resident's condition. [FN73] The form also includes information about the resident's race. [FN74] This information is recorded on the resident assessment instrument and then coded and ***1186** transmitted to the Minimum Data Set (“MDS”). [FN75] The MDS information is used to compile reports, such as the Facility Quality Measure/Indicator Report, which are used during the survey and certification process to determine whether the care provided to individual residents conforms to the Medicare and Medicaid conditions of participation. [FN76]

If the survey team finds the nursing home out of compliance with the Medicare or Medicaid conditions of participation based on the MDS information and visits to the nursing home to observe the residents, it cites the facility for a deficiency [FN77] and issues a Statement of Deficiencies (“SOD”) detailing the nursing home's noncompliance and factual incidents to support the allegations. [FN78] In the SOD, each deficiency is assigned a scope and severity level based on the egregiousness of the offense. [FN79] The scope is the number of residents affected and the severity level refers to the seriousness of the harm. [FN80] The severity levels include actual harm and serious actual harm posing a risk of death (immediate jeopardy). [FN81] This means that the more egregious the deficiency, the poorer the quality of the nursing home.

Once the findings of noncompliance are finalized, penalties are imposed, findings are made public on the Nursing Home Compare website, [FN82] and the state long-term care ***1187** ombudsman, the physicians and skilled nursing facility administration licensing board,

and the state Medicaid fraud and abuse control units are notified. [FN83] The Nursing Home Compare website provides information regarding the overall quality of Medicaid- and/or Medicare-certified nursing homes.

In 2008, CMS moved to a star rating for quality, which is published on the Nursing Home Compare website. [FN84] The quality rating of nursing homes ranges from 1 for poor care to 5 for excellent care. [FN85] A nursing home's overall quality star rating is based on information from the nursing home survey and certification results and the MDS information submitted by the nursing home. [FN86] A plethora of research studies have noted racial disparities in the provision of quality nursing home care both in terms of poor patient outcomes and quality ratings. [FN87]

B. Poor Patient Outcomes

Manifested in many different ways and forms, poor quality care ratings often translate into poor health outcomes for African Americans compared to Caucasians. A study of several states, including New York, Kansas, Mississippi, and Ohio, found that the quality of care provided to Caucasians and African Americans is different. [FN88] African Americans usually receive poor quality care when compared to Caucasians. For example, the resident assessment instruments [FN89] showed that late-stage pressure sores are more common to African Americans, while early-stage pressure sores are more common to Caucasians. [FN90] According to the researchers, the higher rates of late-stage pressure sores in African Americans occur because they are commonly underdiagnosed. [FN91] Hence, Caucasians received treatment before the pressure sores became too severe, while African Americans and other minorities suffered without treatment until the pressure sores became irreparable. [FN92]

***1188** A 2008 study consisting of data from 8,997 nursing homes located in urban cities throughout the continental United States [FN93] found that African American nursing home residents were more likely than Caucasian residents to be hospitalized for “dehydration, poor nutrition, bedsores and other ailments because of a gap in the quality of in-house [nursing home] medical care.” [FN94] These ailments arise when residents are not receiving proper care. Researchers noted that of the 516,082 patients tracked, nineteen percent were hospitalized by the end of the 150-day follow-up period. [FN95]

Of the nursing home residents hospitalized, twenty-four percent were African Americans, while only nineteen percent were Caucasians. [FN96] The study further showed incremental increases in the risk of hospitalization for all nursing home residents regardless of their race or payment status as the percentage of African American residents in the nursing home increased. [FN97]

Finally, data shows that African Americans are less likely than Caucasians to “receive appropriate pharmacologic management for a myriad of conditions and less likely to receive physical therapy upon admission.” [FN98] Thus, the health of African Americans residing in nursing homes is often poorer than that of Caucasians residing in nursing homes.

C. Poor Quality Ratings by the Government

The quality of nursing home care is further assessed by nursing homes' compliance with Medicare and/or Medicaid conditions of participation. For example, national data compiled from the MDS information showed that African Americans reside in nursing homes with “lower ratings of cleanliness/maintenance and lighting.” [FN99] The data also demonstrated that African Americans were admitted to nursing homes with forty-four percent more deficiencies than the nursing homes to which Caucasians were admitted. [FN100]

In a 2004 national study of nursing home quality, researchers noted that the nursing home system was a two-tiered system--“high” and “low.” Characteristics of the “low-tiered” facilities include having Medicaid as the primary source of payment, poor quality of care, and a disproportionate number of African Americans. [FN101] These *1189 low-tiered facilities have fewer nurses, more quality-of-care deficiencies, higher incidences of pressure sores, higher rate of use of physical restraints, and have less pain control and inadequate use of antipsychotic medications. [FN102]

This study showed further that nine percent of Caucasians reside in low-tiered facilities compared to forty percent of African Americans. [FN103] African Americans were three to five times more likely to be in low-tiered facilities than Caucasians. [FN104] 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 Medicare and Medicaid programs because of quality-of-care deficiencies. [FN105] However, the termination of these homes has not led to African Americans being placed in better quality homes. [FN106]

Moreover, a recent national study released in 2007 determined that African Americans were 1.41 times as likely as Caucasians to be in a nursing home cited with a deficiency that caused at least actual harm, 1.70 times as likely to stay in homes that were terminated from the Medicare and Medicaid programs, and 1.12 times more likely to be in a nursing home that was greatly understaffed relative to the residents' needs. [FN107] Racial disparities in the provision of nursing home care are even more significant within individual states.

For instance, an investigation of Illinois nursing homes by the Reporter showed that of the fifty-one predominately African American nursing homes located in Illinois, none were given an excellent rating, i.e. a five-star rating. [FN108] Twenty-nine percent of predominately Caucasian nursing homes in Chicago received five-star ratings. [FN109] The predominately African American facilities received the worst federal ratings, a one, for quality and on average have more deficiencies than facilities where a majority of residents are Caucasian. Specifically, the Reporter found that in Chicago, the worst rating--a one on a five-point scale--was given to fifty-seven percent of African American nursing homes, compared with eleven percent of Caucasian nursing homes. [FN110] “The Reporter also found that the staff at Illinois' black nursing homes spent less time daily with residents than staff at facilities where a majority of the residents are white.” [FN111]

Overall, a review of the empirical data provides a dismal picture of the accessibility of quality nursing home care available to elderly African Americans. A majority of African

Americans reside in poor quality nursing homes compared to *1190 Caucasians. [FN112] However, African Americans' poor health status leaves them reliant on nursing home care with minimal options.

IV. African Americans Can't Get out of the System: Poor Health Status of Elderly African Americans

Between 2000 and 2030, the elderly African American population is projected to grow by 168%, while the elderly population of Caucasians is expected to grow by 90%. [FN113] Although African Americans receive poor-quality care compared to Caucasians, African Americans are forced to continue to reside in nursing homes for several reasons.

First, many Caucasians no longer reside in nursing homes in part because of the creation of new long-term care service providers. Studies show that “an explosive expansion of private-pay assisted-living developments in the 1990s, which served predominantly Caucasian and relatively affluent clientele,” decreased the number of Caucasians living in nursing homes. [FN114] The siphoning off of Caucasians has created an excess nursing home capacity so that nursing homes are filled with African American patients. [FN115]

Second, “[e]ven after adjusting for income differences, the burden of disability falls heaviest on elderly minorities.” [FN116] Born and raised during the Jim Crow era of legalized racial discrimination, elderly African Americans lacked equal access to health care services for most of their lives, and thus are more disabled than their white counterparts. [FN117]

Research indicates that relative to Caucasians, elderly African Americans have higher rates of hypertension. [FN118] In fact, elderly African Americans are more disabled than Caucasians and have the fewest years of active life remaining. [FN119] These results are at every age among the elderly beginning at sixty years old. [FN120] Consequently, elderly African Americans need more access to nursing home services to fulfill their daily *1191 activities, such as showering, toileting, and eating. [FN121] Nevertheless, the data shows that African Americans receive fewer services than Caucasians. [FN122] Thus, African Americans cannot get out of the system because elderly African Americans' health status is compromised, making them more disabled and reliant on nursing home care.

Three decades of empirical data show that African Americans remain limited by their race as they try to access quality nursing home care. [FN123] But how can this be the case in a post-racial era? I discuss the reasons for the continuation of racial disparities in the provision of quality nursing home care in the next section.

V. Reasons for Racial Disparities in Quality

Three reasons have been suggested to explain why racial disparities in the quality of nursing homes persist: socioeconomic status, geographical racial segregation, and racial bias. [FN124] I submit that each of these reasons is inextricably linked and due to structural, institutional, and interpersonal racial bias.

Operating at a societal level, structural bias privileges some groups, such as the rich Caucasians, while denying others access to health care, [FN125] while institutional bias operates through organizational structures and “establishes separate and independent barriers,” such as racial segregation, through the neutral denial of access to quality health care “that results from the normal operations of the institutions in a society.” [FN126] Finally, interpersonal bias is expressed in individual interactions. [FN127]

A. Structural Bias: Socioeconomic Status

Structural bias in nursing home care allows those with privilege, such as the wealthy Caucasians, to obtain the best quality care available. [FN128] Those without *1192 privilege, such as poor minorities, are relegated to poor quality facilities. For example, although nursing homes remain the central institutional provider of care for the elderly and disabled, some elderly and disabled patients now reside in other long-term care facilities including assisted living facilities [FN129] and continuing care retirement communities. [FN130] The growth of private-pay assisted living developments and continuing care retirement communities in the 1990s, which served predominately Caucasian and relatively affluent clientele, decreased the number of Caucasians living in nursing homes. [FN131] Nursing homes were left serving poor minorities, who are more disabled, which is significant because usually these nursing homes are understaffed and provide fewer services. [FN132]

Studies show that quality nursing home care is linked to the availability of resources. [FN133] A nursing home's resources are primarily determined by its source of revenue, i.e. payment source. [FN134] Nursing homes that are primarily reliant on Medicaid payments have limited resources available because Medicaid generally pays below private-pay rates and is often below the actual cost of providing care. [FN135] The overreliance on Medicaid payments leaves these homes without resources to provide adequate staffing or high quality nursing home care. [FN136] Unfortunately, nursing homes that primarily rely on Medicaid payments disproportionately serve African American patients. [FN137]

Furthermore, as discussed in Section III.C, a 2004 study deemed facilities whose primary source of payment is Medicaid as “low-tiered facilities” because of their poor *1193 quality. [FN138] Due to limited resources, these homes often have markers of poor-quality care such as fewer nurses, more quality-of-care deficiencies, and higher incidences of pressure sores. [FN139] Research shows that “African Americans residing in nursing homes were nearly four times as likely to reside in a home with limited resources and historically poor performance than were white patients.” [FN140] In fact, one study found that higher Medicaid payment rates were associated with fewer occurrences of pressure sores and use of physical restraints. [FN141]

Nursing homes in resource-poor areas that disproportionately rely on Medicaid for revenue tend to provide poor care. Unfortunately, data shows that forty-one percent of African Americans admitted to nursing homes rely on Medicaid as a primary payer versus twenty-three percent of Caucasians. [FN142] African Americans are 2.64 times as likely as Caucasians to reside in nursing homes that house primarily Medicaid residents. [FN143] Thus, the

structure of nursing home care privileges the wealthy and Caucasians by allowing them to reside in quality facilities, while the poor and minorities are relegated to substandard nursing homes. Due to this structural bias, nursing homes provide the most care to those that are privileged and wealthy, rather than providing the most services to those who are the most disabled, elderly African Americans.

B. Institutional Bias: Residential Segregation

The institutional practices of nursing homes, such as concentrating good quality nursing homes in affluent neighborhoods, disproportionately disadvantage African Americans. The best quality nursing homes have been shown to reside in predominately Caucasian neighborhoods and have a predominately Caucasian population. [FN144] Unlike certificate of need programs that were used to regulate the location of hospitals, nursing homes have complete discretion in where to locate their facilities. Hence, nursing home owners have left predominately poor and minority neighborhoods without health care services to relocate to over-served affluent areas. [FN145] Regardless of the location of the facility, the nursing home remains racially *1194 segregated, which is linked to racial disparities in the provision of quality nursing home care.

Scholars have suggested that geographical racial segregation is the fundamental cause of racial disparities in nursing homes. [FN146] Nationally, the racial segregation of nursing homes varies; however, the Midwest has the highest degree of racial segregation. [FN147] African Americans are placed in racially segregated, poor quality nursing homes because that is all that is available in the neighborhoods in which they live. [FN148] In fact a study released in 2007 found that “[n]ursing homes remain relatively segregated, roughly mirroring the residential segregation within metropolitan areas,” which results in poor outcomes for African Americans residing in these segregated nursing homes. [FN149] Specifically, predominately African American nursing homes have worse care than predominately Caucasian nursing homes. For example, in Illinois no predominately African American nursing home received an excellent quality rating, whereas 29% of predominately Caucasian nursing homes were rated as excellent. [FN150] Thus, racial segregation in nursing homes is significant because it is linked to the quality of care provided in nursing homes.

Even if geographical racial segregation is one of the reasons for racial disparities in the provision of quality nursing home care, 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 bias. [FN151] 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.” [FN152] This racial *1195 segregation is not self-imposed by African Americans as they “reflect the highest support for residence in integrated neighborhoods.” [FN153] Racial bias is also a factor in residential segregation in nursing homes.

A study of racial segregation in nursing homes reviewed nursing home care in four states: Kansas, Mississippi, New York, and Ohio. [FN154] In Mississippi, New York, and Ohio,

census data showed that the percentage of African Americans residing in predominately Caucasian neighborhoods was much higher than the population of African Americans residing in nursing homes in those neighborhoods. [FN155] 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. [FN156] Additionally, research has shown that interpersonal racial bias in admission practices by nursing homes has kept nursing homes racially segregated. [FN157] Hence, regardless of when one views the problem of racial disparities in health care--at the point of selection of residence in the neighborhood or at the point of selection of residence in a nursing home--interpersonal racial bias is a barrier to African Americans gaining access to safe, quality health care.

C. Interpersonal Bias

Notwithstanding structural and institutional bias, traditional interpersonal racial bias remains. Research suggests that some of the nursing home admission staff in predominately Caucasian neighborhoods use preferences to keep out African Americans. For example, in North Carolina, some nursing homes deny admission to African Americans because some Caucasian nursing home residents wanted to room with those of the same race. [FN158] In New York, studies show that some quality nursing homes deny admission to African Americans, relegating them to substandard nursing homes. [FN159] In Ohio a nursing home was alleged to deny admission to African Americans because of their race. [FN160] Additionally, some nursing home staff at Illinois's African American nursing homes spent less time daily with residents than staff at facilities where a majority of the residents were Caucasian. [FN161] In fact, Caucasian "seniors had qualitatively better nursing home options than black seniors--in some cases, even *1196 when facilities had the same owner." [FN162] These occurrences are not explained by residential segregation or socioeconomic status. [FN163]

Furthermore, even though there was a disparity in spending on quality of care in nursing homes that rely primarily on private pay and those that rely on Medicaid, there remains a racial disparity in the quality of care provided by nursing homes that rely on Medicaid. The Reporter analyzed the ratings for Chicago homes whose primary payment source was Medicaid and found that racial disparities in quality persisted. [FN164] Specifically, the study found that "[a] quarter of white homes received an excellent rating, compared with none of the black homes. More than half of the black homes received the worst rating, while 8 percent of white homes earned the same score." [FN165]

As the data shows, African American patients are overrepresented in poorer quality nursing homes as a result of racial bias. Structural and institutional bias relegates African Americans to racially segregated under-resourced nursing homes, and interpersonal bias leaves African Americans without equal access to quality nursing home services compared to Caucasians. Currently, the regulations governing the provision of quality nursing home care fail to address racial bias in any form. [FN166] Because the nursing home regulatory system not only fails to address the root cause of racial disparities in the provision of quality nursing home care--racial bias, but also is guilty of exhibiting the same bias, it will never alleviate the harm

suffered by African Americans, i.e. unequal access to quality nursing home care. One glaring example of the failure of the nursing home regulatory system to improve the quality of care African Americans receive in nursing homes is the SFF initiative, which is discussed below.

VI. The SFF Initiative: The Promise of Better Quality

Thirteen years ago, CMS initiated the SFF Initiative to stimulate quality-of-care improvements in nursing homes with a history of serious quality issues. Since 2000, research has shown that nursing homes that serve African Americans tend to have a history of serious quality issues, [FN167] yet these nursing homes are hardly ever included in the SFF Initiative because of institutional bias. If predominately African American nursing homes are included on the list, the care provided at the facility rarely improves enough for the facility to be removed from the list because of structural, institutional, and interpersonal racial bias. These predominately African American nursing homes are allowed to continue to provide poor quality health care while predominately Caucasian nursing homes placed in these programs are forced to improve the quality of care they provide. Hence, instead of stimulating quality improvements in care, the SFF *1197 initiative actually perpetuates the racial disparities in the provision of quality nursing home care.

A. SFF Initiative

Notwithstanding the conditions of participation requirements of the Medicare and Medicaid Acts as discussed in Section III.A, a plethora of nursing homes consistently provide poor quality care to residents. These nursing homes periodically fix a sufficient number of deficiencies, which enables them to pass one survey, only to fail the next survey with the same deficiencies as before. [FN168] According to CMS, the “yo-yo” compliance of these nursing homes “rarely address[es] the underlying systemic problems that were giving rise to repeated cycles of serious deficiencies.” [FN169] Thus, CMS implemented the SFF Initiative, which identifies 136 nursing homes that are poor-performing facilities (yo-yo facilities with serious quality issues), puts them on a public SFF list, and works with the facilities to improve the quality of care provided in the nursing homes. [FN170]

Although nursing homes on the SFF list are supposed to represent those with the worst survey findings in the country, based on the most recent three years of survey history, CMS and the states have some discretion. Specifically, the selection of the nursing homes on the SFF Initiative is based on a five-step process. [FN171] The first two steps are tabulating the score of the health deficiencies and the number of revisits. Then the scores are assigned to the year, with the most recent results heavily weighted. CMS uses the scores to make a list, and the fifteen facilities with the highest scores are presented to the state for consideration. [FN172] Each state has discretion in selecting fifteen SFF nursing homes from the CMS candidate list and makes a final recommendation to CMS. [FN173]

Once a nursing home is added to the list, states are required to conduct twice the number of standard surveys to improve the quality of care provided by the nursing home. [FN174] If the SFF nursing home does not improve:

CMS applies progressive enforcement until the nursing home either (a) graduates from the Special Focus program because it makes significant improvements that last; or (b) is terminated from participation in the Medicare and Medicaid programs; or (c) is given more time due to a trendline of improvement and promising developments, such as sale of the *1198 nursing home to a new owner with a better track record of providing quality care. [FN175]

Recently, CMS analyzed the effectiveness of the SFF Initiative by comparing the 128 nursing homes selected in 2005 with those on the list that were not selected. Over the course of two years, “approximately 42 percent of the Special Focus nursing homes had significantly improved to the point of meeting the [SFF] graduation criteria, whereas only 29 percent of the alternates had so improved.” [FN176] Moreover, CMS found that SFF nursing homes were more likely to change ownership or close and “[a]pproximately 15 percent of the Special Focus nursing homes were terminated from participation in Medicare compared with less than 8 percent in the alternates and 2 percent for all other nursing homes.” [FN177] CMS’s study showed improvement in SFF nursing homes, yet there are still problems with the program.

B. Problems with SFF Initiative

Although research studies show that predominately African American nursing homes provided worse quality care than predominately Caucasian nursing homes, these predominately African American nursing homes are rarely on the SFF list because regulators do not put them on the list. [FN178] This is a form of institutional bias because it “establishes separate and independent barriers” through the neutral “denial of opportunities and equal rights to individuals and groups that results from the normal operations of the institutions in a society.” [FN179] If by chance, the predominately African American nursing homes with poor quality are on the SFF list, they usually do not improve their care enough to graduate from the SFF list because regulators fail to address the root causes of the poor quality: all forms of racial bias. [FN180]

1. Failure to Make List

In a report dated August 28, 2009, the U.S. Government Accountability Office (“GAO”) criticized the SFF list because CMS identified the fifteen worst nursing homes per state instead of identifying the worst quality nursing homes in the country. [FN181] Thus, some nursing homes on the list actually provide better care than nursing homes in other states. Analyzing deficiency data for the nation’s roughly 16,000 nursing homes during their three most recent inspection cycles as of December 2008 and using the same five-step process to create the SFF list, the GAO identified 580 nursing homes they called the most poorly performing homes in the country, 448 more than CMS. [FN182]

*1199 The Chicago Reporter combined the GAO data with Dr. Vincent Mor’s racial data to determine the racial composition of the 580 nursing homes. The Reporter’s study showed that Illinois had the most predominately African American nursing homes on the GAO list: twelve. [FN183] Six of the twelve predominately African American nursing homes in the Reporter’s study had poorer quality ratings than the two predominately African American nursing

homes currently on the October 22, 2009 SFF list. [FN184] The SFF list also fails to include predominately Caucasian nursing homes that are poor-performing facilities. [FN185] Nevertheless, there is still a racial disparity between these predominately African American and predominately Caucasian nursing homes. Nationwide predominately African American nursing homes on the GAO list have the most serious deficiencies compared to predominately Caucasian nursing homes. The magnitude of the problem is best illustrated by using the GAO data and Reporter's study to compare the worst predominately African American nursing home in Illinois (Regal Health and Rehab Center, Inc.), [FN186] with the worst predominately Caucasian nursing home in Illinois (McAllister Nursing and Rehab).

For the last four years, the number of times that Regal Health and Rehab Center, Inc. and McAllister Nursing and Rehab were visited for surveys was almost equal (fourteen versus fifteen), yet the results were different. Since 2007, Regal Health and Rehab Center, Inc. has been cited for immediate jeopardy, meaning it "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident," [FN187] in five different surveys. [FN188] Since 2007, McAllister Nursing and Rehab was cited for immediate jeopardy in two different surveys. [FN189] Although McAllister Nursing and Rehab had more instances of immediate jeopardy in fewer surveys, more harm was done to the residents of Regal Health and Rehab Center, Inc. Specifically, two people died at Regal Health and Rehab Center, Inc., one person was severely burned, several people were hospitalized because of infection, and one person had to be sent to the *1200 hospital in order to stop uncontrollable bleeding caused by the staff. [FN190] Residents at McAllister Nursing and Rehab also suffered and were also hospitalized for infection, and one resident suffered a fracture, but no one died. [FN191] In 2009, McAllister was fined once for providing poor quality, [FN192] while Regal Health and Rehab Center, Inc. was fined twice for providing poor quality. [FN193] Even though both homes have serious quality issues, based on the survey and certification data, Regal Health and Rehab Center, Inc. has a more serious quality issue than McAllister Nursing and Rehab. [FN194]

Regal Health and Rehab Center, Inc. is only one example of predominately African American nursing homes that should have been on the SFF list. According to empirical research, a significant number of predominately African American nursing homes provide substandard quality health care, particularly when compared to predominately Caucasian nursing homes. [FN195] Consequently, the SFF Initiative could have been a useful program in addressing the quality disparity between predominately African American nursing homes and predominately Caucasian nursing homes. The SFF Initiative has been effective in improving the quality of care provided to nursing home residents. [FN196] Yet, while poor-performing Caucasian nursing homes are added to the SFF list and stimulated to improve care, poor-performing African American nursing homes are ignored. If the SFF List included the poorest performing nursing homes, more predominately African American nursing homes would be on the list. This is illustrated by the GAO list, which showed that the poor-performing predominately African American nursing homes had more serious deficiencies than predominately Caucasian nursing homes on the GAO list and the SFF list. [FN197] Therefore, predominately African American nursing homes should have been on the SFF list because these nursing homes were the poorest performing nursing homes. The GAO used the same five-step process that CMS used, so the problem is not with the five-step process. I submit that the problem is discretion,

which in this instance is a form of institutional bias.

***1201** The selection of nursing homes for the SFF list is left to the discretion of regulators. [FN198] Rather than simply putting the worst quality nursing homes on the list, regulators are allowed to use discretion to choose the facilities on the list. [FN199] Due to this discretion, poor-performing predominately African American nursing homes are not placed on the SFF list. Hence, this discretion, used in the normal operation of the SFF Initiative, denies African Americans opportunities and equal rights to quality improvement programs, which establishes a separate and independent barrier to quality nursing home care. [FN200] This is institutional bias. In order to eradicate this separate and independent barrier, discretion must be removed from the selection process of the SFF Initiative and replaced with transparency and substantiated reasoning. This is the only way to ensure that institutional bias is removed from the process of selection for the SFF Initiative and more predominately African American nursing homes are included on the list.

2. Failure to Improve Quality

Even if a predominately African American nursing home is added to the SFF list, it may not improve the quality of the nursing home care provided. For example, the International Nursing and Rehab Center, a predominately African American nursing home in Chicago, Illinois, has been on the list for seventy-three months, over six years, and has not improved the quality of care it provides enough to be removed from the SFF list. [FN201] In fact, residents continue to die in the facility unnecessarily.

For instance, on September 19, 2006, Luzella Roberts was placed in the International Nursing and Rehab Center. [FN202] After only six days at the facility, she suffered irreparable harm during dialysis that ultimately led to her death. On September 25th, the nurse inserted a syringe in Mrs. Roberts's left arm, although Mrs. Roberts's medical chart specifically instructed that dialysis was to be conducted using "a catheter that was surgically implanted in Roberts' right arm" not through the left arm. [FN203] The syringe remained there for three hours. It was removed when "Roberts' daughter, Cynthia Wade, stopped by to visit and saw her mother's arm and face gray and swollen. Wade began screaming at the nurse to remove the needle." [FN204] When the nurse removed the needle, "Roberts' arm began to bleed uncontrollably and she was rushed to the emergency room." [FN205] Roberts remained at the hospital and on October 10, 2006, she underwent a procedure to stem the bleeding in her arm. [FN206] Initially, the bleeding stopped, but started again one week later. Consequently, Mrs. Roberts underwent ***1202** additional surgery on October 19th and 25th. Mrs. Roberts continued to deteriorate, and she died on October 31, 2006. [FN207] Unfortunately, this was not the only death that occurred at International Nursing and Rehab Center that was linked to the facility's poor care.

On August 29, 2007, a resident got caught in his bedside rails and died. [FN208] His death actually occurred while International Nursing and Rehab Center was listed on the SFF list. Notwithstanding this fact, International Nursing and Rehab Center remains certified to participate in the Medicare and Medicaid programs and is still on the most recent SFF List dated February 17, 2011. [FN209] The SFF Initiative is supposed to address the underlying systemic

problems that cause serious deficiencies; [FN210] yet it does not because it fails to address or acknowledge the structural, institutional, and interpersonal racial bias, which are the systemic problems that cause predominately African American nursing homes to provide substandard care.

The structure of the nursing home system, like the structure of the health care system, is based on ability to pay, not need. As a result of their socioeconomic status, African Americans are relegated to poor-performing nursing homes, while the wealthy and Caucasians are able to afford to stay in quality nursing homes or assisted living facilities. Institutional bias, which erects separate and independent barriers, keeps nursing homes racially segregated, which is linked to racial disparities in quality. Data shows that the best quality nursing homes are located in predominately Caucasian neighborhoods and have a predominately Caucasian population. [FN211] Interpersonal bias keeps African Americans from being admitted to some quality nursing homes and placed in nursing homes that are underfunded and understaffed. [FN212] The SFF Initiative does not address any form of racial bias.

Regulators do not provide any nursing home, particularly predominately African American nursing homes, on the SFF list with additional resources. Instead they impose more fines on the nursing home, exacerbating the resource differential that already exists between some predominately Caucasian and predominately African American nursing homes. Additionally, the SFF Initiative does not address nursing home admission policies or the severe understaffing of predominately African American nursing homes. By failing to address these forms of bias, regulators permit nursing home owners and staff to concentrate in affluent non-minority areas, deny admission to African Americans, and provide fewer resources to predominately African American nursing homes. Therefore, it is no wonder that predominately African American nursing homes disproportionately provide substandard care. As evidenced by the problems with the SFF Initiative, improving the quality of care in predominately African American nursing homes cannot be accomplished until the root cause of the *1203 poor quality, racial bias, is acknowledged and addressed. [FN213] Until then predominately African American nursing homes will continue to provide substandard care compared to predominately Caucasian nursing homes.

VII. Conclusion

African American patients are overrepresented in poorer quality nursing homes, and research shows that African Americans residing in nursing homes “were nearly four times as likely to reside in a home with limited resources and historically poor performance than were white patients.” [FN214] These disparities are a result of structural, institutional, and interpersonal bias. Nine years after the IOM's study on Unequal Treatment, the time has come for the promise of equal access to quality health to become a reality. There is no easy solution to address racial bias, but it definitely cannot be fixed through race-neutral means as evidenced by the continuation of racial disparities in nursing home care. If we are to truly address and rectify the unequal treatment of African Americans in the health care system, then Americans must eliminate the barriers erected by all forms of racial bias, which prevents African Americans from accessing health care, particularly nursing home care.

[FNa1]. Visiting Professor, University of Connecticut, 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. Many thanks to Frank McClellan, Ron Iller, Linda Gehring, and Joshua Zissman for putting together an excellent Conference on Health Disparities that featured numerous valuable contributions, and the editors of Temple Law Review. For their able research, I thank Kathleen Dolan, Damon Doucet, and Dan Spira.

[FN1]. This is an excerpt adapted from Jeff Kelly Lowenstein's article entitled Disparate Nursing Home Care, Chi. Rep., http://www.chicagoreporter.com/index.php/c/Web_Exclusive/d/Disparate_Nursing_Home_Care (last visited Mar. 4, 2011).

[FN2]. Id.

[FN3]. Id.

[FN4]. Id.

[FN5]. Id.

[FN6]. Several research studies show that even when payment status is controlled there are still significant disparities in access and quality of nursing home care that are only explained based on a difference in the patient's race. See David Falcone & Robert Broyles, [Access to Long-Term Care: Race as a Barrier](#), 19 *J. Health Pol. Pol'y & L.* 583, 588-92 (1994) (providing research showing that African American hospital patients experience greater discharge delays to nursing homes than Caucasian patients); 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) (summarizing literature on racial differences in nursing homes); David Barton Smith, [The Racial Integration of Health Facilities](#), 18 *J. Health Pol. Pol'y & L.* 851, 862-64, 866 (1993) (presenting findings that African Americans have less access to nursing homes, as well as more segregated care); 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) (noting that non-whites experience longer delays in awaiting placement into nursing homes).

[FN7]. Inst. of Med., *Unequal Treatment: Confronting Racial and Ethnic Inequities in Health Care* (2002).

[FN8]. See supra note 6 for a discussion of disparities of access and quality of nursing home care. I have focused exclusively on the disparities in care between African Americans and Caucasians because currently the empirical data has primarily focused on the stark differences between these groups. See, e.g., David R. Williams, Race, Socioeconomic Status, and Health: The Added Effects of Racism and Discrimination, 896 *Annals N.Y. Acad. Sci.* 173, 174-75 (1999) (noting reasons for focus on disparities between African Americans and Caucasians and analyzing differences in mortality rates for African Americans and Caucasians). However, recent research has focused on Hispanic elderly. See Mary L. Fennell et al., Elderly Hispanics More Likely to Reside in Poor-Quality Nursing Homes, 29 *Health Aff.* 65, 65 (2010) (noting

disparities in nursing home care between Hispanics and non-Hispanic whites).

[FN9]. See Falcone & Broyles, *supra* note 6, at 588-92 (finding in 1994 that African American hospital patients experience greater discharge delays to nursing homes than Caucasian patients); Fennell et al., *supra* note 6, at 174-76 (summarizing literature in 2000 article on racial differences in nursing homes); David C. Grabowski, *The Admission of Blacks to High-Deficiency Nursing Homes*, 42 *Med. Care* 456, 458 (2004) (noting that whites were admitted to nursing homes with fewer deficiencies than non-whites); Vincent Mor et al., *Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care*, 82 *Milbank Q.* 227, 237-38 (2004) (noting that nine percent of whites are in lower-tiered nursing homes compared to forty percent of African Americans); Smith, *supra* note 6, at 862-63 (presenting findings in 1993 that African Americans have less access to nursing homes, as well as more segregated care); Weissert & Cready, *supra* note 6, at 632, 642 (noting in 1988 that non-whites experience longer delays in awaiting placement into nursing homes).

[FN10]. See N.Y. State Advisory Comm. to U.S. Comm'n on Civil Rights, *Minority Elderly Access to Health Care and Nursing Homes 5* (1992) [hereinafter *Minority Elderly Access*] (documenting use of race and religion as factors in nursing home placement); Falcone & Broyles, *supra* note 6, at 588-92 (noting longer delays in placement from hospitals to nursing homes for African Americans in North Carolina); Fennell et al., *supra* note 6, at 178-79 tbl.3 (discussing racial disparities in New York nursing homes); Weissert & Cready, *supra* note 6, at 632, 642 (discussing racial disparities in nursing homes in North Carolina); Ronald Sullivan, *New Rules Sought on Nursing Homes*, *N.Y. Times*, May 5, 1985, at 46 [hereinafter *Sullivan, New Rules Sought*] (noting that New York planned to investigate nursing homes with significantly low numbers of minority patients); Ronald Sullivan, *Study Charges Bias in Admission to Nursing Homes*, *N.Y. Times*, Jan. 28, 1984, at 27 [hereinafter *Sullivan, Study Charges Bias*] (summarizing study finding that minorities in New York were excluded from better nursing homes).

[FN11]. See David Barton Smith et al., *Separate and Unequal: Racial Segregation and Disparities in Quality Across U.S. Nursing Homes*, 26 *Health Aff.* 1448, 1451-52 (2007) (finding that African Americans were concentrated in small percentage of American nursing homes); Steven P. Wallace et al., *The Persistence of Race and Ethnicity in the Use of Long-Term Care*, 53B *J. Gerontology: Psychol. Sci. & Soc. Sci.* S104, S104-06 (1998) (noting racial disparities in use of institutional long-term care).

[FN12]. See *Minority Elderly Access*, *supra* note 10, at 3-6 (observing existence of empirical research documenting discrimination against African Americans in admissions to nursing homes in New York State); Fennell et al., *supra* note 6, at 174-76 (noting that minorities in nursing homes are more likely to receive poor care than whites); Mor et al., *supra* note 9, at 237-39 (finding that African Americans are much more likely than Caucasians to be placed in lower-tier facilities); Jeff Kelly Lowenstein, *Lower Standards*, 38 *Chi. Rep.*, July-Aug. 2009, at 8, 10-14 (noting that African Americans are placed in nursing homes with lowest standard ratings throughout United States).

[FN13]. See Falcone & Broyles, *supra* note 6, at 592 (noting that race is greater indicator of

delay of nursing home placement than age or sex); Fennell et al., *supra* note 6, at 179 (hypothesizing that in racially mixed communities, nursing home with homogenous staff will result in higher racial disparities in quality of care); Kelly Lowenstein, *supra* note 12, at 13 (stating that Caucasians get better care than African Americans, even controlling for socioeconomic status); Weissert & Cready, *supra* note 6, at 632, 642 (noting that race is determinant in delays in nursing home placement).

[FN14]. According to the United States Department of Health and Human Services,

Long-term care ... includes medical and non-medical care to people who have a chronic illness or disability. Long-term care helps meet health or personal needs. Most long-term care is to assist people with support services such as activities of daily living like dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, in assisted living or in nursing homes. It is important to remember that you may need long-term care at any age.

U.S. Dep't of Health & Human Servs., What is Long-Term Care?, <http://www.medicare.gov/LongTermCare/static/Home.asp> (last visited Mar. 4, 2011).

[FN15]. Kelly Lowenstein, *supra* note 12, at 10.

[FN16]. U.S. Dep't of Health & Human Servs., Health, United States, 2008, 392 tbl.107 (2009). This disparity is projected to continue. *Id.*

[FN17]. See David Barton Smith et al., [Racial Disparities in Access to Long-Term Care: The Illusive Pursuit of Equity](#), 33 *J. Health Pol. Pol'y & L.* 861, 877-79 (2008) (positing residential segregation as contributing to disparity); Smith et al., *supra* note 11, at 1456 (suggesting racial bias as factor but describing disparity situation as “Gordian Knot”); Ruqaiyah Yearby, [Striving for Equality, But Settling for the Status Quo in Health Care: Is Title VI More Illusory Than Real?](#), 59 *Rutgers L. Rev.* 429, 462-70 (2007) (positing geographic segregation and racial bias as contributing to disparity).

[FN18]. Leith Mullings & Amy J. Schulz, Intersectionality and Health: An Introduction, in *Gender, Race, Class, & Health* 3, 12 (Amy J. Schulz & Leith Mullings eds., 2006).

[FN19]. *Id.*

[FN20]. *Id.* at 13.

[FN21]. See Janice A. Sabin et al., Physicians' Implicit and Explicit Attitudes About Race by MD Race, Ethnicity, and Gender, 20 *J. Health Care for Poor & Underserved* 896, 907 (2009) (concluding that doctors have explicit and implicit attitudes about race).

[FN22]. Racial bias is prohibited by Title VI of the Civil Rights Act of 1964. See Civil Rights Act of 1964, 42 U.S.C. §§ 2000d-2000d-1 (2006). Although Title VI compliance is mentioned in the regulations governing the nursing home regulatory system, the systems remain separate. 42 C.F.R. § 442.12(d)(2) (2010); 45 C.F.R. § 80.3 (2010). For instance, Title VI enforcement and nursing home enforcement systems are enforced by different federal and state entities, with no collaboration. For a full discussion see, Ruqaiyah Yearby, [Litigation, Integration, and](#)

[Transformation: Using Medicaid to Address Racial Inequities in Health Care](#), 13 *J. Health Care L. & Pol'y* 325, 325-91 (2010).

[FN23]. U.S. Gov't Accountability Office, GAO-09-689, *Nursing Homes: CMS's Special Focus Facility Methodology Should Better Target the Most Poorly Performing Homes, Which Tended to Be Chain Affiliated and For-Profit*, at Highlights, 1 (2009).

[FN24]. The U.S. Department of Health and Human Services (“HHS”) is the federal agency in charge of regulating the quality of care provided by nursing homes that receive funding from the Medicare and/or Medicaid programs. The U.S. Department of Health, Education, and Welfare was renamed to HHS in 1980. See Department of Education Organization Act of 1979, Pub. L. No. 96-88, § 509(e), 93 Stat. 695 (codified as 20 U.S.C. § 3508 (2000)).

[FN25]. Ctrs. for Medicaid & Medicare Servs., *Special Focus Facility Background Info and List*: 2/17/2011, at 1 (2011), <http://www.cms.gov/CertificationandCompliance/Downloads/SFFList.pdf>.

[FN26]. *Id.*

[FN27]. See Chicago Reporter Data of SFF list (2009) (crosslisting SFF List with racial data from Vincent Mor) (on file with author).

[FN28]. Kelly Lowenstein, *supra* note 1; Grabowski, *supra* note 9, at 458; Mor et al., *supra* note 9, at 237-38.

[FN29]. Ctrs. for Medicaid & Medicare Servs., *supra* note 25; Ctrs. for Medicaid & Medicare Servs., *Special Facility Focus Background Info and List*: 12/23/2009 (2009) (on file with author); Ctrs. for Medicaid & Medicare Servs., *Special Facility Focus Background Info and List*: 10/22/2009 (2009) (on file with author) [hereinafter Ctrs. for Medicaid & Medicare Servs., 10/22/2009].

[FN30]. “Assisted living is for adults who need help with everyday tasks. They may need help with dressing, bathing, eating, or using the bathroom, but they don't need full-time nursing care.... Assisted living costs less than nursing home care.” Medline Plus, *Assisted Living* (2010), <http://www.nlm.nih.gov/medlineplus/assistedliving.html>.

[FN31]. See Fennell et al., *supra* note 6, at 174-76 (noting that previous studies found link between race and access to nursing homes); Grabowski, *supra* note 9, at 462 (concluding that racial discrimination factors into denial of access of African Americans to nursing homes); Smith, *supra* note 6, at 857, 860-61 (noting that race is better indicator of access to nursing homes than income); Weissert & Cready, *supra* note 6, at 632, 642 (noting that non-whites experience longer delays in being admitted into nursing homes).

[FN32]. See Sullivan, *New Rules Sought*, *supra* note 10, at 46 (noting that New York planned to investigate nursing home with significantly low number of minority patients); Sullivan, *Study Charges Bias*, *supra* note 10, at 27 (summarizing study finding that minorities in New York were excluded from better nursing homes).

[FN33]. Sullivan, Study Charges Bias, *supra* note 10, at 27.

[FN34]. Minority Elderly Access, *supra* note 10, at ii.

[FN35]. *Id.* at 5.

[FN36]. U.S. Dep't of Health & Human Servs., The National Nursing Home Survey: 2004 Overview, 19 *tbl.17* (2009). In 2004, there were 16,100 nursing homes with an occupancy rate of eighty-six percent. *Id.* at 32 *tbl.1*.

[FN37]. 2 Encyclopedia of American Industry, Service and Non-Manufacturing Industries SIC 8051, at 1350 (Lynn M. Pearce ed., 4th ed. 2005), available at <http://www.referenceforbusiness.com/industries/Service/Skilled-Nursing-Care-Facilities.html>.

[FN38]. Barbara Messinger-Rapport, Disparities in Long-Term Healthcare, 44 *Nursing Clinics N. Am.* 179, 180 (2009).

[FN39]. *Id.*

[FN40]. Smith et al., *supra* note 11, at 1451-52.

[FN41]. *Id.*

[FN42]. See Fennell et al., *supra* note 6, at 180 (hypothesizing that racial segregation affects quality of care in nursing homes); Grabowski, *supra* note 9, at 456 (examining relationship between racial disparities in nursing homes and government deficiency ratings); Smith, *supra* note 6, at 860-61 (finding that race is better indicator than indigency of location in substandard facilities).

[FN43]. See Kelly Lowenstein, *supra* note 12, at 10-11 (examining low government ratings of nursing homes that are predominately African American in Illinois); Mor et al., *supra* note 9, at 237-39 (stating that lower-tier nursing homes are more likely to serve African Americans).

[FN44]. Medicare is a federal entitlement program to pay for health insurance for the elderly and disabled. See generally Social Security Act, 42 U.S.C. §§ 1395-1397 (2006).

[FN45]. Medicaid is a state- and federally funded program to pay for medical assistance for the poor. The states administer this program. See *id.* § 1396a (authorizing appropriation of funds to states to furnish medical assistance to those who are unable to meet costs of necessary medical services).

[FN46]. The Secretary of Health and Human Services is required to regulate the actual care provided to residents to ensure that nursing homes “provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.” See *id.* §§ 1396a(a)(10)(B), 1396r(b)(2).

[FN47]. See Kelly Lowenstein, *supra* note 12, at 10-11 (examining low government ratings of nursing homes in Illinois that are predominately African American); Mor et al., *supra* note 9,

at 237-39 (stating that lower-tier nursing homes are more likely to serve African Americans).

[FN48]. See Yearby, *supra* note 17, at 436-37.

[FN49]. See 42 U.S.C. § 1395kk (explaining administration of Medicare).

[FN50]. See *id.* § 1396-1 (appropriating funds to states that submit plans for medical assistance to Secretary of Health). In 1977, the Centers for Medicare and 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) (noting that, at that time, Social Security Act was administered by Health Care Financing Administration and extending its authority to newly acquired territories); Centers for Medicare and Medicaid Services; Statement of Organization, Functions and Delegations of Authority; Reorganization Order, 66 Fed. Reg. 35,437, at 35,437-503 (July 5, 2001) (announcing establishment of Centers for Medicare & Medicaid Services). To prevent any confusion, this Article solely refers to the agency as CMS. For state-operated nursing homes, CMS has the responsibility for certifying nursing homes to participate in Medicaid and reviews their annual compliance with the Medicaid Act. 42 U.S.C. § 1396r. Usually, CMS determinations are based on state survey findings. *Id.* § 1395aa.

[FN51]. 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 (2009) (establishing survey frequency, and requiring extended survey).

[FN52]. *Id.* §§ 488.300-.335.

[FN53]. *Id.* § 488.314 (defining composition of survey teams).

[FN54]. 42 U.S.C. § 1395i-3(g)(2)(A) (2006). The majority of nursing homes are also certified to participate in the Medicaid program. See 42 C.F.R. § 488.300 (2009) (stating survey determines both Medicare and Medicaid eligibility). Thus, the survey team usually cites the nursing home for both Medicare and Medicaid violations. *Id.* §§ 488.330(a)(1)(i), (b) (describing process for certification and noting dual participation facilities).

[FN55]. See 42 U.S.C. § 1396r (establishing requirements for nursing homes' provision of services).

[FN56]. *Id.* § 1396r(c)(4)(A) (stating requirement that facility must care for residents in a way that maintains or improves quality of life).

[FN57]. *Id.* § 1395i-3(g)(2). Because both the federal government and the states provide funding for Medicaid certified nursing homes, the regulation of these homes incorporates both federal and state law. Furthermore, if a nursing home is certified to participate in both Medicare and Medicaid, it must meet the requirements and undergo the regulation processes of both programs. 42 C.F.R. § 488.301.

[FN58]. *Id.* § 483.10.

[FN59]. Id. § 483.13.

[FN60]. Id. § 483.15.

[FN61]. Id. § 483.20.

[FN62]. Id. § 483.25.

[FN63]. Id. § 483.30.

[FN64]. Id. § 483.35.

[FN65]. Id. § 483.40.

[FN66]. Id. § 483.45.

[FN67]. Id. § 483.55.

[FN68]. Id. § 483.60.

[FN69]. Id. § 483.65.

[FN70]. Id. § 483.70.

[FN71]. Id. § 483.12.

[FN72]. Id. § 483.75.

[FN73]. Id. § 483.20(b).

The main components of the initiative are nursing home quality measures derived from resident assessment data. This information is routinely collected by nursing homes at specified intervals during a resident's stay (using the Minimum Data Set or MDS). These measures provide additional information to help consumers make informed decisions about nursing home care options. Publication of the measures is intended to motivate nursing homes to improve care delivery and encourage discussions about quality between consumers and clinicians.

[Medicare and Medicaid Programs; Requirements for Long Term Care Facilities; Nursing Services; Posting of Nurse Staffing Information, 70 Fed. Reg. 62,065 \(Oct. 28, 2005\)](#) (codified at 42 C.F.R. pt. 483).

[FN74]. See [42 C.F.R. § 483.20\(b\)\(i\)](#) (requiring that assessment include demographic information).

[FN75]. Id. § 483.20(f). MDS data is recorded in the MDS Repository and is available to the public. Id.

[FN76]. Ctrs. for Medicaid & Medicare Servs., State Operations Manual, Appendix P: Survey Protocol for Long-Term Care Facilities app. P., at 2, 11 (rev. 2009), http://cms.hhs.gov/manuals/Downloads/som107ap_p_ltcf.pdf. During the survey and certifica-

tion process, the states use a Resident Assessment Instrument to check the nursing home's Minimum Data Set information for errors. *Id.* at 18.

[FN77]. 42 C.F.R. § 488.301. 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, on the basis of which HHS can cite a nursing home. See U.S. Dep't of Health & Human Servs., Office of the Inspector Gen., 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, quality of life, *id.* § 483.15, and resident behavior and facility practice, *id.* § 483.13. Medicaid regulations are based exclusively on the Medicare regulations, but differ slightly on specific deficiency number designations.

[FN78]. See 42 C.F.R. § 488.402(f)(1) (providing for notice of nature of noncompliance, remedies imposed, and right to appeal). The state submits its findings on HHS's Online Survey Certification and Reporting system for HHS approval. 42 C.F.R. §§ 488.330(d), 488.402(f)(1). Upon approval from HHS, the state agency sends a copy of the SOD to the offending nursing home along with a letter noting all the remedies imposed. See 42 C.F.R. §§ 488.18(b)(1), 488.402(f)(2) (requiring state agency to provide notice of remedies). Even after HHS approves the SOD, nursing homes can appeal any deficiencies or remedies through an informal dispute resolution process. 42 C.F.R. § 488.331. "Reductions in the number, scope, and severity of citations are common" Robert H. Lee et al., Reliability of the Nursing Home Survey Process: A Simultaneous Survey Approach, 46 Gerontologist 772, 773 (2006).

[FN79]. 42 C.F.R. § 488.404(a).

[FN80]. *Id.* § 488.404(b). The scope of the deficiency means whether the deficiency was isolated, constituted a pattern of behavior, or was widespread. *Id.* § 488.404(b)(2). The severity is whether a facility's deficiencies caused: "(i) [n]o 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 resident health or safety." *Id.* § 488.404(b)(1).

[FN81]. *Id.* § 488.404(b).

[FN82]. Social Security Act, 42 U.S.C. § 1395i-3(h)(2) (2009). The information remains posted until the next annual survey is conducted.

[FN83]. See 42 U.S.C. § 1395i-3(g)(5) (mandating disclosures).

[FN84]. U.S. Gov't Accountability Office, *supra* note 23, at Highlights.

[FN85]. *Id.*

[FN86]. U.S. Dep't of Health & Human Servs., Ctrs. for Medicaid & Medicare Servs., Nursing Home Compare, <http://www.medicare.gov/NHCompare> (last visited Mar. 4, 2011). The qual-

ity rating of Medicaid-certified nursing homes is based on three categories: health inspections, staffing levels, and quality measures. *Id.* The health inspection rating is based on information from state surveys. *Id.* The staffing level rating is based on information from state surveys and information submitted by the nursing homes. *Id.* The quality measure rating is based on information submitted by the nursing home from the MDS. *Id.*

[FN87]. Fennell et al., *supra* note 6, at 174; Grabowski, *supra* note 9, at 456; Mor et al., *supra* note 9, at 227; Smith, *supra* note 6, at 857, 860-61.

[FN88]. Fennell et al., *supra* note 6, at 174. The authors also noted that “[i]ndeed, it is possible for a nursing home to provide, on average, high quality of care and to also exhibit a substantial disparity in the levels of care received by majority and minority residents.” *Id.*

[FN89]. 42 C.F.R. § 483.20(b)(1) (2008). A nursing home is required to assess the condition of every resident within fourteen days of a resident's admission and whenever there is a significant change in the resident's condition. *Id.* § 483.20(b)(2). This data is then coded and transmitted to the Minimum Data Set (MDS), which is used by states to determine the quality of care in nursing homes. *Id.* § 483.20(f).

[FN90]. Fennell et al., *supra* note 6, at 175-76.

[FN91]. *Id.* at 176.

[FN92]. *Id.*

[FN93]. Andrea Gruneir et al., *Relationship Between State Medicaid Policies, Nursing Home Racial Composition, and the Risk of Hospitalization for Black and White Residents*, 43 *Health Services Res.* 869, 871 (2008).

[FN94]. Jackie Spinner, *Illness, Race Tied in Study of Care: Comparison Made at Nursing Homes*, *Wash. Post*, Jan. 15, 2008, at B1.

[FN95]. Gruneir et al., *supra* note 93, at 874.

[FN96]. *Id.* Additionally, the percentage of residents who had to be hospitalized strongly correlated with the patient's Medicaid status and the states' Medicaid rate. *Id.* at 877. Increasing the Medicaid reimbursement rate by ten dollars “reduced the odds of hospitalization by 4 percent ... for white residents and 22 percent ... for black residents.” *Id.* at 869. This suggests that race and Medicaid payment rates are inextricably linked.

[FN97]. *Id.* at 877.

[FN98]. *Id.* at 869 (citations omitted).

[FN99]. Grabowski, *supra* note 9, at 456.

[FN100]. *Id.* at 458.

[FN101]. See Mor et al., *supra* note 9, at 235-39, 241 (discussing characteristics of low-tier fa-

cilities and impact of Medicaid and race on classification of facilities as low tier).

[FN102]. *Id.*

[FN103]. *Id.* at 237-38.

[FN104]. *Id.* at 238. This ratio varies by state from zero to nine, and the only state where the ratio is zero is Kentucky. *Id.*

[FN105]. *Id.* at 245.

[FN106]. See *id.* at 245-46 (predicting that nursing home closures due to deficiencies may make it more difficult for African Americans to find nursing homes).

[FN107]. Smith et al., *supra* note 11, at 1452.

[FN108]. Kelly Lowenstein, *supra* note 12, at 10.

[FN109]. *Id.*

[FN110]. *Id.*

[FN111]. *Id.* at 10-14.

[FN112]. Mor et al., *supra* note 9, at 238; Kelly Lowenstein, *supra* note 12, at 10.

[FN113]. 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).

[FN114]. Smith et al., *supra* note 17, at 876.

[FN115]. *Id.*

[FN116]. U.S. Comm'n on Civil Rights, *Civil Rights Issues in Health Care Delivery* 292 (1980). "For example, 59 percent of elderly blacks with incomes less than 55 percent of poverty suffer limitations of activity, compared to 51.1 percent for whites with the same income level" *Id.* See Steven P. Wallace et al., *The Consequences of Color-Blind Health Policy for Older Racial and Ethnic Minorities*, 9 *Stan. L. & Pol'y Rev.* 329, 335 (1998) (indicating that older minorities have "higher levels of disability, fewer economic resources, and different patterns of using long-term care").

[FN117]. See Wallace et al., *supra* note 11, at S104-05 (discussing factors contributing to racial disparities in healthcare access).

[FN118]. Rodney Clark, *Significance of Perceived Racism: Toward Understanding Ethnic Group Disparities in Health, the Later Years*, in *Critical Perspectives on Racial and Ethnic Differences in Health in Late Life* 540, 550 (Norman B. Anderson et al., eds. 2004).

[FN119]. Robert Hummer et al., Racial and Ethnic Disparities in Health and Mortality Among the U.S. Elderly Population 66-67, in *Critical Perspectives on Racial and Ethnic Differences in Health in Late Life*, supra note 118, at 53, 64-69.

[FN120]. Id.

[FN121]. Wallace et al., supra note 11, at S104; see also Steven P. Wallace, The Political Economy of Health Care for Elderly Blacks, 20 *Int'l J. Health Services* 665, 672-76 (1990) (describing that generally older African Americans have poorer health status compared with older Caucasians).

[FN122]. See Smith et al., supra note 17, at 877 (noting racial disparities in nursing home quality of care). Even though African Americans may be more disabled, studies show that there is essentially no difference in the resources required to care for Caucasians and African American nursing home patients. Id.

[FN123]. Fennell et al., supra note 6, at 174; Grabowski, supra note 9, at 456; Mor et al., supra note 9, at 227-28; Smith, supra note 6, at 857, 860-61.

[FN124]. For a fuller discussion of the reasons for racial disparities in quality in nursing home care, see Yearby, supra note 17, at 462-70.

[FN125]. Mullings & Schulz, supra note 18, at 12.

[FN126]. Vernellia R. Randall, Why Race Matters?, <http://academic.udayton.edu/health/03access/data.htm> (last visited Mar. 4, 2011).

[FN127]. Mullings & Schulz, supra note 18, at 12.

[FN128]. Much scholarship has focused on describing institutional and structural racism. See Derrick A. Bell, Jr., *Race, Racism and American Law* 712-27 (3d ed. 1992) (racism in labor markets and housing markets); Stephen J. Gould, *The Mismeasure of Man* (1981) (racism in biology); Jonathan Kozol, *Savage Inequalities: Children in America's Schools* (1991) (racism in education); Kimberlé Williams Crenshaw, Foreword: Toward a Race-Conscious Pedagogy in Legal Education, 11 *Nat'l. Black L.J.* 1 (1989) (discussing how taboo surrounding race affects legal education); Kimberlé Williams Crenshaw, [Race, Reform, and Retrenchment: Transformation And Legitimation In Antidiscrimination Law](#), 101 *Harv. L. Rev.* 1331 (1988); Charles R. Lawrence, [Who Is the Child Left Behind?: The Racial Meaning of the New School Reform](#), 39 *Suffolk U. L. Rev.* 699 (2006).

[FN129]. “Assisted living is for adults who need help with everyday tasks. They may need help with dressing, bathing, eating, or using the bathroom, but they don't need full-time nursing care.... Assisted living costs less than nursing home care.” Medline Plus, Assisted Living (2010), <http://www.nlm.nih.gov/medlineplus/assistedliving.html>.

[FN130]. The Medicaid and Medicare website describes “continuing care retirement communities” as follows:

Continuing Care Retirement Communities (CCRCs) provide housing, health care,

and social services. In the same community, there may be individual homes or apartments, an assisted living facility, and a nursing home. Where you live depends on the level of care you need.

... Some CCRCs offer a “life care contract.” This means, if you need care in the assisted living facility or in the nursing home, then you are guaranteed to pay the same entry fee and monthly fee as someone who lives in an individual home or apartment.

Ctrs. for Medicaid & Medicare Servs., *Paying for Long Term Care: Continuing-Care Retirement Communities*, <http://www.medicare.gov/longTermCare/static/ContinuingCare.asp?dest=NAV|Paying|HomeEquity|ContinuingCare> (last visited Mar. 4, 2011).

[FN131]. Smith et al., *supra* note 17, at 876.

[FN132]. Mor et al., *supra* note 9, at 228; Kelly Lowenstein, *supra* note 12, at 10.

[FN133]. Gruneir et al., *supra* note 93, at 870.

[FN134]. Mor et al., *supra* note 9, at 228.

[FN135]. *Id.*; see also David C. Grabowski et al., *Medicaid Payment and Risk-Adjusted Nursing Home Quality Measures*, 23 *Health Aff.* 243, 249 (2004) (noting positive relationship between Medicaid funding and certain quality indicators).

[FN136]. See Smith et al., *supra* note 11, at 1456 (arguing that financial viability of nursing homes depends on proportion of private-pay patients).

[FN137]. *Id.* at 1452-53.

[FN138]. See Mor et al., *supra* note 9, at 241 (noting definition of “lower-tier” reflects facility's disproportionate share of Medicaid patients).

[FN139]. Mary L. Fennell, *Racial Disparities in Care: Looking Beyond the Clinical Encounter*, 40 *Health Services Res.* 1713, 1717 (2005) (citing Mor et al., *supra* note 9, at 238).

[FN140]. *Id.* at 1717.

[FN141]. Grabowski et al., *supra* note 135, at 248-49. Earlier studies found that a link between poor quality and Medicaid payments was also affected by the market demand in the area of the nursing home. See, e.g., Paul J. Gertler, *Subsidies, Quality, and the Regulation of Nursing Homes*, 38 *J. Pub. Econ.* 33, 51 (1989) (arguing that higher Medicaid payment would not necessarily improve nursing home care quality); John A. Nyman, *Prospective and ‘Cost-Plus’ Medicaid Reimbursement, Excess Medicaid Demand, and the Quality of Nursing Home Care*, 4 *J. Health Econ.* 237, 237 (1985) (arguing that excess Medicaid demand resulted in low-quality nursing home care).

[FN142]. Grabowski, *supra* note 9, at 460.

[FN143]. Smith et al., *supra* note 11, at 1452-53.

[FN144]. Mor et al., supra note 9, at 227-28; Grabowski, supra note 9, at 456; Fennell et al., supra note 6, at 174.

[FN145]. Smith et al., supra note 11, at 1456.

[FN146]. Wallace, supra note 116, at 674-76; see generally Smith et al., supra note 11, at 1451-52; Williams, supra note 8, at 177-79; David R. Williams & Chiquita Collins, Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health, 116 Pub. Health Rep. 404, 404 (2001).

[FN147]. Smith et al., supra note 11, at 1456.

[FN148]. Wallace, supra note 116, at 674-76.

[FN149]. Smith et al., supra note 11, at 1448.

[FN150]. Kelley Lowenstein, supra note 1, at 12.

[FN151]. Jacqueline L. Angel & Ronald J. Angel, Minority Group Status and Healthful Aging: Social Structure Still Matters, 96 Am. J. Pub. Health 1152, 1154 (2006); Wallace, supra note 116, at 674; Williams, supra note 8, at 177-80; Williams & Collins, supra note 146, at 404-07.

[FN152]. Williams, supra note 8, at 178; see also Clear and Convincing Evidence: Measurement of Discrimination in America (Michael Fix & Raymond J. Struyk eds., 1993) (discussing empirical study cited by Supreme Court in [Gratz v. Bollinger](#), 539 U.S. 244, 300 n.7 (2003), to show continuation of racial discrimination in United States); Douglas S. Massy & Nancy A. Denton, *American Apartheid: Segregation and the Making of the Underclass* (1993) (cited by the U.S. Census Bureau in its Housing Patterns--“Racial and Ethnic Residential Segregation in the United States: 1980-2000” as support of the continuation of racial discrimination in housing); Wallace, supra note 111, at 674 (noting continued segregation in nursing home care). See generally David Delaney, *Race, Place, & the Law: 1836-1948*, at 145 (1998) (analyzing role of geography in racial segregation); Leland Ware, [The Demographics of Desegregation: Residential Segregation Remains High 40 Years After the Civil Rights Act of 1964](#), 49 St. Louis U. L.J. 1155 (2005) (arguing that housing discrimination persists since Civil Rights Act); Leland Ware, [Race and Urban Space: Hypersegregated Housing Patterns and the Failure of School Desegregation](#), 9 Widener L. Symp. J. 55 (2002) (analyzing relationship between housing discrimination and school desegregation); 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, 78 (1993) (analyzing shortcomings of fair housing statutes).

[FN153]. Williams, supra note 8, at 178.

[FN154]. Fennell et al., supra note 6, at 178-80.

[FN155]. Id. Kansas was the only state that did not show these disparities.

[FN156]. Id.

[FN157]. Falcone & Broyles, *supra* note 6, at 588-92; Weissert & Cready, *supra* note 6, at 632, 642.

[FN158]. See Falcone & Broyles, *supra* note 6, at 591 (speculating that a longer delay in African American placement in nursing homes was due to racial preferences in patient roommate selection); Weissert & Cready, *supra* note 6, at 642 (same).

[FN159]. Minority Elderly Access, *supra* note 10, at ii-iii; Sullivan, Study Charges Bias, *supra* note 10; Sullivan, New Rules Sought, *supra* note 10.

[FN160]. See Brief of Plaintiff, at 4-6, [United States v. Lorantffy Care Ctr.](#), 999 F. Supp. 1037 (N.D. Ohio 1998) (No. 97-cv-00295) (case filed by federal government against a nursing home for violating the Fair Housing Act based on evidence of racial discrimination).

[FN161]. Kelly Lowenstein, *supra* note 12, at 10.; Gruneir et al., *supra* note 93, at 874; Mor et al., *supra* note 9, at 235-39, 241.

[FN162]. See *id.* at 14 (noting disparate ratings among black and white homes belonging to same owner).

[FN163]. *Id.* at 10-14.

[FN164]. *Id.* at 13. “Primary source of payment” means that Medicaid paid more than seventy-five percent of residents' care. *Id.* at 12.

[FN165]. *Id.* at 13.

[FN166]. The prohibition against racial bias in the provision of health care is mentioned in the regulations governing the nursing home regulatory system, yet the prohibition is not a part of the annual survey and certification system. 42 C.F.R. § 442.12(d)(2) (2010); 45 C.F.R. §80.3 (2010).

[FN167]. Kelly Lowenstein, *supra* note 12, at 10.; Mor et al., *supra* note 9, at 235-39.

[FN168]. Ctrs. for Medicaid & Medicare Servs., *supra* note 25.

[FN169]. Statement of Kerry Weems, Acting Administrator Centers for Medicare & Medicaid Services, Before the Senate Special Committee on Aging 7-8 (Nov. 15, 2007), available at [http:// www.hhs.gov/asl/testify/2007/11/t20071115d.html](http://www.hhs.gov/asl/testify/2007/11/t20071115d.html).

[FN170]. See generally U.S. Gov't Accountability Office, GAO-10-197, Poorly Performing Nursing Homes: Special Focus Facilities Are Often Improving, but CMS's Program Could Be Strengthened (2010).

[FN171]. Ctrs. for Medicaid & Medicare Servs., Special Focus Facility Program Survey Scoring Methodology, available at [http:// www.cms.gov/surveyscertificationgeninfo/pmsr/itemdetail.asp?itemid=CMS1215978](http://www.cms.gov/surveyscertificationgeninfo/pmsr/itemdetail.asp?itemid=CMS1215978) (last visited Mar. 4, 2011).

[FN172]. Id.

[FN173]. Id.

[FN174]. Ctrs. for Medicaid & Medicare Servs., supra note 25.

[FN175]. Statement of Kerry Weems, supra note 169, at 7-8.

[FN176]. Id.

[FN177]. Id.

[FN178]. Kelley Lowenstein, supra note 1, at 12; Mor et al., supra note 9, at 246.

[FN179]. Randall, supra note 126.

[FN180]. Ctrs. for Medicaid & Medicare Servs., 10/22/2009, supra note 29.

[FN181]. U.S. Gov't Accountability Office, supra note 23, at 31-32.

[FN182]. Id.

[FN183]. One of which was on the SFF list. Chicago Reporter Data, supra note 27. The Chicago Reporter's study also shows that some of the worst Caucasian nursing homes are missing from the SFF list.

[FN184]. Chicago Reporter Data, supra note 27; Ctrs. for Medicaid & Medicare Servs., 10/22/2009, supra note 29.

[FN185]. Chicago Reporter Data, supra note 27

[FN186]. Recently, the name of Regal Health and Rehab Center, Inc. was changed to Oaklawn Respiratory & Rehab. However, the survey findings and inclusion in the GAO data occurred while the facility was named Regal Health and Rehab Center, Inc. See Statement of Deficiencies, Aug. 4, 2009; Statement of Deficiencies, Apr. 17, 2008; Statement of Deficiencies, Jan. 23, 2008; Statement of Deficiencies, Mar. 21, 2007; Statement of Deficiencies, Jan. 23, 2007, available at <http://www.idph.state.il.us/webapp/LTCApp/federalsurvey.jsp?facilityid=600677>. It is unclear whether this resulted from a change in ownership. However, it does not matter because a change of ownership does not erase the survey and certification history or provider number. 42 C.F.R. § 442.14 (2010). Therefore, I refer to the facility as the Regal Health and Rehab Center, Inc.

[FN187]. 42 C.F.R. § 488.301 (2010).

[FN188]. See Statement of Deficiencies, Aug. 4, 2009; Statement of Deficiencies, Apr. 17, 2008; Statement of Deficiencies, Jan. 23, 2008; Statement of Deficiencies, Mar. 21, 2007; Statement of Deficiencies, Jan. 23, 2007, available at <http://www.idph.state.il.us/webapp/LTCApp/federalsurvey.jsp?facilityid=600677>.

[FN189]. See Statement of Deficiencies, Jun. 19, 2008; Statement of Deficiencies, Dec. 14, 2007, available at <http://www.idph.state.il.us/webapp/LTCApp/federalsurvey.jsp?facilityid=600590>.

[FN190]. See Statement of Deficiencies, Aug. 4, 2009, at 10; Statement of Deficiencies, Apr. 17, 2008, at 2-4, 58-60; Statement of Deficiencies, Mar. 21, 2007, at 37-39; Statement of Deficiencies, Jan. 23, 2007, at 1-5, 9, available at <http://www.idph.state.il.us/webapp/LTCApp/federalsurvey.jsp?facilityid=600677>.

[FN191]. See Statement of Deficiencies, Jun. 19, 2008, at 1-10, 13-20; Statement of Deficiencies, Dec. 14, 2007, at 13-28, 30-38, 93-100, 123-28, 147-56, 159-63, 163-68, available at <http://www.idph.state.il.us/webapp/LTCApp/federalsurvey.jsp?facilityid=600590>.

[FN192]. The Illinois Department of Public Health, Quarterly Reports of Nursing Home Violators, Oct.-Dec. 2009, available at http://www.idph.state.il.us/about/nursing_homes_violations09/quarterly_report_4-09.htm.

[FN193]. The Illinois Department of Public Health, Quarterly Reports of Nursing Home Violators, Apr.-June 2009, available at http://www.idph.state.il.us/about/nursing_homes_violations09/quarterly_report_2-09.htm; The Illinois Department of Public Health, Quarterly Reports of Nursing Home Violators, July-Sept. 2009, available at http://www.idph.state.il.us/about/nursing_homes_violations09/quarterly_report_3-09.htm.

[FN194]. Nevertheless, both homes remain certified to participate in the Medicare and Medicaid programs and are missing from the most recent SFF List, leaving the residents vulnerable. Ctrs. for Medicaid & Medicare Servs., *supra* note 25.

[FN195]. Kelley Lowenstein, *supra* note 1, at 12; Mor et al., *supra* note 9, at 246.

[FN196]. Statement of Kerry Weems, *supra* note 169, at 7-8.

[FN197]. U.S. Gov't Accountability Office, *supra* note 23, at 31-32.

[FN198]. Ctrs. for Medicaid & Medicare Servs., *supra* note 171.

[FN199]. Regulators are supposed to use their intimate knowledge of the states' nursing homes to determine which nursing homes should be placed on the list. *Id.* Yet, this still allows for great discretion, which is unreviewable. *Id.*

[FN200]. Randall, *supra* note 126.

[FN201]. Ctrs. for Medicaid & Medicare Servs., *supra* note 25.

[FN202]. This is an excerpt adapted from Jeff Kelly Lowenstein's article, *supra* note 12, at 10.

[FN203]. *Id.*

[FN204]. *Id.*

[FN205]. Id.

[FN206]. Id. at 14.

[FN207]. A civil lawsuit has been filed alleging that the nursing home caused Mrs. Roberts's death. Id.

[FN208]. See Statement of Deficiencies, Oct. 24, 2007, at 1-6 (on file with author).

[FN209]. Ctrs. for Medicaid & Medicare Servs., supra note 25.

[FN210]. Id.

[FN211]. Mor et al., supra note 9, at 227-28; Grabowski, supra note 9, at 456; Fennell et al., supra note 6, at 174.

[FN212]. Falcone & Broyles, supra note 6, at 588-92; Weissert & Cready, supra note 6, at 632, 642; Kelly Lowenstein, supra note 1, at 10.

[FN213]. For further discussion about the need to integrate the nursing home regulatory system with the civil rights system, see Yearby, supra note 22, at 325-91 (2010).

[FN214]. Fennell, supra note 139, at 1717.
82 Temp. L. Rev. 1177

END OF DOCUMENT