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Litigation, Integration, and Transformation: Using Medicaid to Address Racial Inequities in Health Care

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LITIGATION, INTEGRATION, AND TRANSFORMATION: USING MEDICAID TO ADDRESS RACIAL INEQUITIES IN HEALTH CARE

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TABLE OF CONTENTS

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PREFACE

Kelley Mitchell, a 75-year-old woman, lives alone in Terrell Park, an affluent neighborhood in a major city in the Midwest. One day while rushing to the telephone, she slips and falls down the stairs and is immediately raced to the hospital in her neighborhood. Diagnosed with a hip fracture, she has surgery and recuperates in the hospital for several weeks. Her condition improves, but she cannot take care of herself, so the hospital discharge staff plans to transfer her to a nursing home on November 4, 2008. On the same day that Kelley is rushed to the hospital, her friend Blanche Manning, a 75-year-old woman living alone, trips and fractures her hip. Blanche also resides in Terrell Park and is immediately raced to the same hospital as Kelley. Blanche is diagnosed with a hip fracture and recuperates from the surgery for several weeks. Unable to care for herself, Blanche is told by the hospital discharge staff that she will be transferred to a nursing home on November 4, 2008.

Seeking to transfer Kelley, the hospital discharge staff contacts the sole nursing home in Terrell Park, giving Kelley's information and requesting a transfer. The request is rejected because all their Medicaid certified beds are filled. Half an hour later the same discharge staff member contacts the same nursing home on behalf of Blanche, giving her information and requesting a transfer. The nursing home is still out of Medicaid certified beds; however, it accepts Blanche and certifies an additional bed as Medicaid. Blanche is immediately transferred to this high-quality nursing home, while Kelley is transferred to a poor quality nursing home located in an unsafe neighborhood fifty miles from her home. Blanche's nursing home is like a resort, while Kelley's nursing home is atrocious. For example, Kelley is not receiving physical therapy or adequate pain medication. Consequently, Kelley is unable to walk on her own and is in constant pain.

Blanche, however, is in physical therapy, receiving the correct amount of pain medication, and can walk without assistance. Last week both nursing homes were surveyed for compliance with the Medicaid Act's[1] quality of care regulations.[2] Blanche's nursing home did not have any violations, whereas Kelley's nursing home had several violations including failure to provide adequate pain management[3] and services to attain the highest practicable physical well-being of each resident.[4]

Even though their payment status, physical condition, neighborhood of residency, and educational level were the same, Kelley and Blanche were placed in significantly different nursing homes. The only difference is their race. Kelley is African American, and Blanche is Caucasian. Although this story is fictional,[5] empirical data[6] and case law[7] show that the story of these two women is a common occurrence, not an isolated incident, and is most likely caused by racial discrimination.[8]

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1. 42 U.S.C. § 1395i-3(b) (2006 & West Supp. 2009).

2. 42 C.F.R. § 483.25 (2009).

3. *See id.* §§ 483.25(e), (m), .60 (requiring facilities to provide patients with adequate care to improve range of motion, reduce medication errors, and prescribe appropriate drugs); Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., State Operations Manual app. PP (2009), *available at* http://cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf (providing guidance on pain management).

4. *See* 42 C.F.R. § 483.25 ("Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being . . . .").

5. This story is based in part on actual events of racial discrimination in nursing home admission practices. *See* Taylor v. White, 132 F.R.D. 636, 639–40, 644 (E.D. Pa. 1990) (challenging the delay in transfer to nursing homes and the poor quality of care provided to African Americans in Philadelphia nursing homes); Linton *ex rel.* Arnold v. Comm'r of Health & Env't, 779 F. Supp. 925, 927 (M.D. Tenn. 1990) (challenging racial discrimination committed by the state of Tennessee through its policy of limiting the number of Medicaid beds in nursing homes); Brief of Plaintiff at 1, 3–6, United States v. Lorantffy Care Ctr., 999 F. Supp. 1037 (N.D. Ohio 1998) (No. 5:97-CV-00295) (arguing that a nursing home violated the Fair Housing Act based on evidence of racial discrimination).

6. Several research studies show that even when payment status is controlled there are still significant inequities in access and quality of nursing home care that are only explained based on a difference in the patient's race. David Falcone & Robert Broyles, *Access to Long-Term Care: Race as a Barrier*, 19 J. HEALTH POL. POL'Y & L. 583, 588–91 (1994); Mary L. Fennell et al., *Facility Effects on Racial Differences in Nursing Home Quality of Care*, 15 AM. J. MED. QUALITY 174, 174–76 (2000); David Barton Smith, *The Racial Integration of Health Facilities*, 18 J. HEALTH POL. POL'Y & L. 851, 862–64, 866 (1993); William G. Weissert & Cynthia Matthews Cready, *Determinants of Hospital-to-Nursing Home Placement Delays: A Pilot Study*, 23 HEALTH SERVICES RES. 619, 632, 642 (1988).

7. *See* cases cited *supra* note 5.

8. Researchers and jurists have offered innumerable *neutral* reasons, including residential segregation and socioeconomic status, for racial disparities. David Barton Smith et al., *Separate and Unequal: Racial Segregation and Disparities in Quality Across U.S. Nursing Homes*, 26 HEALTH AFF. 1448, 1456 (2007); 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). However, some scholars question the neutrality of residential segregation and socioeconomic status. Jacqueline L. Angel & Ronald J. Angel, Commentary, *Minority Group Status and Healthful Aging: Social Structure Still*

INTRODUCTION

Instances of racial discrimination in health care continue despite the enactment of civil rights laws,[9] such as Title VI of the Civil Rights Act of 1964

Matters, 96 AM. J. PUB. HEALTH 1152, 1154 (2006); Steven P. Wallace, *The Political Economy of Health Care for Elderly Blacks*, 20 INT'L J. HEALTH SERVICES 665, 674 (1990); David R. Williams, *Race, Socioeconomic Status, and Health: The Added Effects of Racism and Discrimination*, 896 ANNALS N.Y. ACAD. SCI. 173, 177–80 (1999); David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 PUB. HEALTH REP. 404, 405–07 (2001). Their research shows that residential segregation and socioeconomic status are inextricably linked to the continuation of racial discrimination. Wallace, *supra* at 674; Williams, *supra* at 177–78; Williams & Collins, *supra* at 407. In fact, Steven Wallace and David Williams believe that the cause of geographic, racial segregation and socioeconomic status is linked to racial discrimination. *See* Wallace, *supra* at 673–78; Williams & Collins, *supra* at 405. Furthermore, recently released nursing home data on race suggests that, although residential segregation is a significant factor in racial inequities in nursing home care, this residential segregation is caused by racial discrimination such as redlining neighborhoods and denying admission to African Americans. Smith et al., *supra* at 1456. Thus, even neutral reasons are not separate from racial discrimination. *See* Ruqaiijah 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) (discussing how racial discrimination plays a part in geographical racial segregation and socioeconomic status).

9. Several articles note the continuation of racial discrimination in health care. *See* Thomas E. Perez, *The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status*, *in* INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 626, 628, 633, 636–37 (Brian D. Smedley et al. eds. 2003) (discussing how racial discrimination is subtle yet ongoing); Neil S. Calman, *Out of the Shadow: A White Inner-City Doctor Wrestles with Racial Prejudice*, HEALTH AFF., Jan.-Feb. 2000, at 170, 172–74 (explaining how racial prejudices affect and limit patients' health care opportunities); Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catherization*, 340 NEW ENG. J. MED. 618, 618, 623–24 (1999) (discussing how race and sex influence physician recommendations in the treatment of cardiovascular disease). Furthermore, there have been several lawsuits that provided extensive empirical data suggesting the continuation of racial discrimination, particularly in nursing homes. *See* cases cited *supra* note 5. For additional discussion of the continuation of racial discrimination in health care, see Brietta R. Clark, *Hospital Flight from Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023, 1028–44, 1056–88 (2005) (discussing how hospital closures in poor minority communities demonstrate persistent racial discrimination in health care and how the current legal structure has not prevented such discrimination); Lisa C. Ikemoto, *In the Shadow of Race: Women of Color in Health Disparities Policy*, 39 U.C. DAVIS L. REV. 1023, 1046–52 (2006) (discussing how the current analysis of racial disparities in health care fails to take into account gender disparities as well, thus continuing a pattern of discrimination against women of color); Dayna Bowen Matthew, *A New Strategy to Combat Racial Inequality in American Health Care Delivery*, 9 DEPAUL J. HEALTH CARE L. 793, 796, 798–821 (2005) (discussing how, despite its success in de-segregating hospitals, Title VI has largely been ineffective in preventing race-based discrimination with respect to quality of care); Kevin Outterson, *The End of Reparations Talk: Reparations in an Obama World*, 57 U. KAN. L. REV. 935, 946–48 (2009) (discussing how President Obama's focus on health reform, and not reparations, might be successful in reducing racial disparities in access to health care); Vernellia R. Randall, *Eliminating Racial Discrimination in Health Care: A Call for State Health Care Anti-Discrimination Law*, 10 DEPAUL J. HEALTH CARE L. 1, 8–24 (2006) (discussing how Title VI has not prevented racial discrimination because the Supreme Court has ruled that it only includes intentional discrimination, and arguing that new federal and state anti-discrimination laws must be enacted that address unintentional discrimination and private institutions); Ruqaiijah Yearby, *Does Twenty-Five Years Make a Difference in "Unequal Treatment"?: The Persistence of Racial Disparities in Health Care Then and Now*, 19 ANNALS HEALTH L. 57, 57–61

(Title VI).[10] Title VI prohibited racial discrimination by health care entities receiving government funding such as Medicaid payments.[11] The federal government focused its initial efforts on hospitals.[12] Because hospitals relied on federal funding, the federal government was able to force hospitals to integrate without much resistance from the hospital industry.[13] However, since this accomplishment the government has relied too heavily on assurances of compliance from other health care entities, such as nursing homes, with minimal follow up.[14] Thus, it comes as no surprise that research studies suggest that racial discrimination persists in the provision of health care, particularly nursing home care.

Research studies discussed in Part I suggest that elderly African Americans disproportionately reside in poor quality nursing homes compared to Caucasians as a result of racially discriminatory practices.[15] For example, research shows that, even when other factors such as residential segregation and socioeconomic status are controlled, significant racial inequities in access to quality nursing home care still exist.[16] Moreover, 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.[17] These studies suggest that racial

(2010) (discussing how current federal programs aimed at elimination of racial discrimination in health care have been successful, and calling "scholars, researchers, and federal officials to adopt a new approach to eradicate racial disparities"); Ruqaiijah Yearby, *African Americans Can't Win, Break Even, or Get Out of the System: The Persistence of Racial Disparities in Health Care in "Post-Racial" America*, 83 TEMPLE L. REV. (forthcoming 2010).

10. 42 U.S.C. §§ 2000d to 2000d-7 (2006).

11. *Id.* §§ 2000d to 2000d-1. Medicaid is a state and federally funded program to pay for medical assistance for the poor. *See id.* § 1396. The states administer this program. *Id.*

12. DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION 246 (1999).

13. *See id.* at 247 tbl.7.1, 248 (indicating that hospitals faced little financial risk, and expanded their markets, by embracing Medicaid).

14. Marianne Engelman Lado, *Unfinished Agenda: The Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery*, 6 TEX. F. ON C.L. & C.R. 1, 28 (2001) (citing Michael Meltsner, *Equality and Health*, 115 U. PA. L. REV. 22, 30–38 (1966)).

15. *See infra* Part I.

16. Falcone & Broyles, *supra* note 6, at 588–92; Fennell et al., *supra* note 6, at 174–76; Weissert & Cready, *supra* note 6, at 632, 642.

17. *See, e.g.*, Falcone & Broyles, *supra* note 6, at 584, 588–91 (discussing a North Carolina study that race is consistently a factor in discharge delay when all other factors are controlled); Fennell et al., *supra* note 6, at 174–75 (reviewing empirical studies that show that minorities do not receive comparable quality of care in nursing homes); Jeff Kelly Lowenstein, *Disparate Nursing Home Care*, CHI. REP., May 27, 2009, *available at* http://www.chicagoreporter.com/index.php/c/Web_Exclusive/d/Disparate_Nursing_Home_Care (discussing a study conducted by Chicago Reporter of twenty-one nursing homes in the Chicago area that found lower quality care in predominantly African American nursing homes even when poverty is controlled for).

discrimination, in the form of both disparate treatment and disparate impact,[18] is the cause.[19]

The continuation of racial discrimination in nursing home care is significant because a large part of the United States population will be over the age of sixty-five within twenty years. By 2030, it is projected that approximately 70 million Americans will be over the age of sixty-five years old—about twenty percent of the

18. Unlike in other industries such as education, in health care the distinction between disparate treatment and disparate impact discrimination has not been clear. *See* Conforming Amendments to the Regulations Governing Nondiscrimination on the Basis of Race, Color, National Origin, Disability, Sex, and Age Under the Civil Rights Restoration Act of 1987, 65 Fed. Reg. 68,050, 68,050–51 (Nov. 13, 2000) (codified in 34 C.F.R. pts. 100, 104, 106, and 110) (discussing "different treatment" and "disparate impact"); David Barton Smith, *Addressing Racial Inequities in Health Care: Civil Rights Monitoring and Report Cards*, 23 J. HEALTH POL. POL'Y & L. 75, 90–91 (1998) (noting a lack of clarity regarding these terms). Many medical journal articles, law review articles, and government reports acknowledge the fact that there is substantial evidence of racial discrimination in the delivery of health care without specifically characterizing what constitutes disparate treatment versus what constitutes disparate impact. *See, e.g.*, U.S. COMM'N ON CIVIL RIGHTS, THE HEALTH CARE CHALLENGE: ACKNOWLEDGING DISPARITY, CONFRONTING DISCRIMINATION, AND ENSURING EQUALITY: VOLUME I THE ROLE OF GOVERNMENTAL AND PRIVATE HEALTH CARE PROGRAMS AND INITIATIVES, at ix (1999) [hereinafter HEALTH CARE CHALLENGE] (discussing both disparate treatment and disparate impact discrimination in health care industry); Falcone & Broyles, *supra* note 6, at 588–92 (discussing racial discrimination as the main reason for unequal treatment without distinguishing between disparate treatment and disparate impact); Vernellia R. Randall, *Racial Discrimination in Health Care in the United States as a Violation of the International Convention on the Elimination of All Forms of Racial Discrimination*, 14 U. FLA. J.L. & PUB. POL'Y 45, 47–65 (2002) (making a distinction between discriminatory practices and disparate impact). In fact, in the 1999 U.S. Commission on Civil Rights Report on *The Health Care Challenge*, the Commission stated that the distinction between disparate treatment and disparate impact racial discrimination was "a matter of splitting hairs. The effect is the same: discrimination." HEALTH CARE CHALLENGE, *supra*, at ix. As noted by Professors Sara Rosenbaum and Joel Teitelbaum, "[t]here is no system for measuring the presence of discrimination" and HHS staff have "no clear policy guidance on how to conduct disparate impact analyses, and [are] generally unable to identify a 'nexus' between existing disparities and a health care practice or policy." Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of* Alexander v. Sandoval, 3 YALE J. HEALTH POL'Y L. & ETHICS 215, 231–33 (2003). Because most of the government agency reports, empirical research studies, and law review articles cited in this Article fail to distinguish between disparate treatment versus disparate impact discrimination in health care, I have chosen not to make a distinction. Thus, when referring to racial discrimination I am referring to all forms of racial discrimination, unless otherwise noted. The failure to make a distinction between disparate treatment versus disparate impact causes numerous problems, such as isolating health care from other areas of civil rights, making health care case precedents inapposite, and erecting insurmountable barriers to attain proof of disparate treatment to support private lawsuits. *See* Martha Chamallas, *Evolving Conceptions of Equality Under Title VII: Disparate Impact Theory and the Demise of the Bottom Line Principle*, 31 UCLA L. REV. 305, 306–10 (1983) (explaining how administrative agencies have set specific policies for disparate impact as well as disparate treatment under Title VII); Daniel K. Hampton, Note, *Title VI Challenges by Private Parties to the Location of Health Care Facilities: Toward a Just and Effective Action*, 37 B.C. L. REV. 517, 517–18, 536–42 (1996) (discussing how minorities have difficulty proving intentional discrimination requiring separate disparate impact, and discussing how health care related cases deal with the validity of a disparate impact claim in relation to a disparate treatment claim).

19. Falcone & Broyles, *supra* note 6, at 591–92; Fennell et al., *supra* note 6, at 174–76; Lowenstein, *supra* note 17.

population.[20] This increase in the elderly population is due to the aging of baby boomers (those born in the post World War II period from 1946 to 1964), who will be sixty-five years or older by 2029.[21] Thus, it is projected that the use of long-term care services,[22] such as nursing homes, will increase from 8 million Americans in 2000 to 19 million in 2050.[23] However, the use of nursing home services is not equal.

Since 1995, the population of African Americans residing in nursing homes has been greater than that of the Caucasian population.[24] Yet, African Americans disproportionately reside in substandard nursing homes compared to Caucasians.[25] Because African Americans disproportionately reside in poor quality nursing homes and this disparity is projected to continue as the elderly population grows,

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20. JENNIFER CHEESEMAN DAY, U.S. DEP'T OF COMMERCE, PUB. NO. P25-1130, POPULATION PROJECTIONS OF THE UNITED STATES BY AGE, SEX, RACE, AND HISPANIC ORIGIN: 1995-2050, U.S. BUREAU OF THE CENSUS CONSUMER POPULATION REPORTS 1, 9 tbl.F (1996), *available at* http://www.census.gov/prod/1/pop/p25-1130.pdf. As of 2006, there were 37 million Americans over the age of sixty-five. FED. INTERAGENCY FORUM ON AGING-RELATED STATISTICS, OLDER AMERICANS 2008: KEY INDICATORS OF WELL-BEING 2 (2008), *available at* http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/2008_Documents/OA_2008.pdf.

21. DAY, *supra* note 20, at 1, 7.

22. The Centers for Medicare and Medicaid Services describes *long-term care* as including:

> [M]edical 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.

CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., WHAT IS LONG-TERM CARE? (2007), http://www.medicare.gov/LongTermCare/static/Home.asp (last visited June 14, 2010).

23. OFFICE OF ASSISTANT SEC'Y FOR PLANNING & EVALUATION, DEP'T OF HEALTH & HUMAN SERVS. ET AL., THE FUTURE SUPPLY LONG-TERM CARE WORKERS IN RELATION TO THE AGING BABY BOOM GENERATION: REPORT TO CONGRESS 3 (2003), *available at* http://aspe.hhs.gov/daltcp/reports/ltcwork.pdf.

24. NAT'L CTR. FOR HEALTH STATISTICS, CTRS. FOR DISEASE CONTROL & PREVENTION, HEALTH, UNITED STATES, 2008, at 392 tbl.107 (2008), *available at* http://www.cdc.gov/nchs/data/hus/hus08.pdf [hereinafter HEALTH, UNITED STATES, 2008]. This disparity is projected to continue. *Id.*

25. *See* N.Y. STATE ADVISORY COMM. TO THE U.S. COMM'N ON CIVIL RIGHTS, MINORITY ELDERLY ACCESS TO HEALTH CARE AND NURSING HOMES 29–30 (1992) (presentation of Joseph N. Kennedy, Acting Regional Manager for the Region II Office for Civil Rights of the U.S. Dep't of Health & Human Servs.) [hereinafter MINORITY ELDERLY ACCESS] (stating that minorities commonly reside in worse nursing homes than Caucasians); 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) (reporting that forty percent of African American nursing home residents live in "lower-tier" facilities, compared to just nine percent of Caucasian nursing home residents); Lowenstein, *supra* note 17 (discussing how, of twenty-one Chicago nursing homes studied, "[e]ach of the three predominantly [African American] facilities received the lowest possible rating in 2009 from Nursing Home Compare, a federal database to evaluate nursing homes that are Medicare- and Medicaid-certified" and "[l]ess than half of . . . [the sixteen] predominantly [Caucasian] facilities received that same rating").

there is great urgency in putting an end to racial inequities in the provision of quality nursing home care.[26]

Notwithstanding this emerging crisis, the government has failed to put an end to racial discrimination by nursing homes receiving public funding. The U.S. Department of Health and Human Services (HHS)[27] is the federal agency in charge of enforcing Title VI compliance for health care entities.[28] HHS delegated its duties to its Office of Civil Rights (OCR); however, HHS has failed to adequately staff and fund OCR's efforts.[29] Consequently, OCR has fallen behind in two of its most significant tasks: investigating private complaints and conducting mandatory system-wide compliance reviews.[30] Specifically, OCR has failed to timely investigate and resolve complaints of racial discrimination, which has "result[ed] in an unstated acceptance of poor or non-existent health care for minorities . . . and a perpetuation of inequality in the United States."[31]

In partnership with HHS, the states enforce Title VI compliance; however, they have not done any better than HHS in putting an end to racial discrimination in health care.[32] To keep costs down, states have continued to give the very nursing homes alleged to deny admission to African Americans, because of their race, unfettered authority to make admission decisions.[33] These governmental failures are reviewed in detail in Part II.[34]

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26. There is also a need for a critical analysis of the structural and institutional problems involving race and class within the health care system. However, first there is a need to implement a framework to collect the data necessary to understand the structural and institutional problems that cause racial inequities in order to craft a solution, which will address these structural and institutional problems. *See* Perez, *supra* note 9, at 637, 655 (discussing the need for a broader research on racial and ethnic disparities in health care).

27. The U.S. Department of Health, Education, and Welfare was renamed the U.S. Department of Health and Human Services (HHS) in 1980. *See* Department of Education Organization Act of 1979 § 509(e), 20 U.S.C. § 3508 (2006).

28. 45 C.F.R. § 80.1 (2009).

29. U.S. COMM'N ON CIVIL RIGHTS, FEDERAL TITLE VI ENFORCEMENT TO ENSURE NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS 219, 222–23 (1996) [hereinafter FEDERAL TITLE VI ENFORCEMENT]; Brietta R. Clark, *supra* note 9, at 1057–59; Rosenbaum & Teitelbaum, *supra* note 18, at 230–31.

30. Clark, *supra* note 9, at 1058; Rosenbaum & Teitelbaum, *supra* note 18, at 231. Both Congress and HHS are responsible for granting funding to OCR. The literature tends to show that when provided with ample funding HHS still cut back on OCR's funding. *See* FEDERAL TITLE VI ENFORCEMENT, *supra* note 29, at 223 (noting the inadequate staff and resources of HHS's Title VI enforcement program).

31. HEALTH CARE CHALLENGE, *supra* note 18, at 9.

32. *See infra* Part II.B.2.

33. HEALTH CARE CHALLENGE, *supra* note 18, at 64; Madonna Harrington Meyer, *Medicaid Reimbursement Rates and Access to Nursing Homes: Implications for Gender, Race, and Marital Status*, 23 RES. ON AGING 532, 534 (2001). The only change by nursing homes was the removal of blatant discriminatory advertising, but subtle racial discrimination continued. *See* Smith, *supra* note 6, at 862 (noting that the only change in nursing homes from Title VI was the inclusion of nondiscriminatory language in advertising signaling the inability to continue to discriminate through advertising).

34. *See infra* Part II.

To fulfill the promise of racial equality in health care, HHS and the states must aggressively monitor and sanction perpetrators in order to end discriminatory practices—a significant change from their historical position of acquiescence. To achieve this end, I argue in Part III that HHS and the states should integrate civil rights enforcement with the nursing home enforcement system.[35] This does not require new legislation or regulation.[36] Instead, using the existing nursing home enforcement system, HHS and the states should review nursing home admission decisions and the quality of care provided to patients for instances of racial discrimination.[37] Once instances of racial discrimination have been identified, HHS and the states should impose fines as required by the nursing home enforcement system and post the information in the public domain to protect and serve consumers' needs.[38]

To induce the government to adopt and implement this integrated system, I suggest in Part IV that Medicaid patients seeking admission to or residing in nursing homes file 42 U.S.C. § 1983 class action suits[39] against the Secretary of HHS (Secretary) and the states alleging that their civil rights are being violated.[40] Building on the foundation of successful precedents,[41] African Americans should argue that the Secretary and the states have failed to enforce the requirements of the

35. *See infra* Part III.

36. *See infra* note 360 and accompanying text.

37. *See infra* Part III.C.

38. *See infra* text accompanying notes 351, 359.

39. *See infra* Part IV. Arguably, African Americans could file a private right of action under other sections of the Civil Rights Act, including 42 U.S.C. § 1981 (equal rights under the law) and § 1982 (property rights) to challenge the racially discriminatory practices of nursing homes. *See* Mahone v. Waddle, 564 F.2d 1018, 1034 (3d Cir. 1977) (establishing a cause of action under 42 U.S.C. §§ 1981 and 1982), *cert. denied* 438 U.S. 904 (1978); *see also* Schneider v. Bahler, 564 F. Supp. 1449, 1455–56 (N.D. Ind. 1983) (recognizing the private right of action established under § 1982). These suits would allow African Americans to sue private nursing homes for racial discrimination. However, claims under §§ 1981 and 1982 would not provide systemic changes and require evidence of specific instances of intentional racism, making these sections no different than the requirements for bringing a Title VI claim. *See, e.g.*, *Schneider*, 564 F. Supp. at 1456 (noting that § 1982 requires a showing of racial intent or impact, as opposed to specific, intentionally racist acts).

40. Even though nursing homes are the perpetrators of the harm, Medicaid patients have no means to directly affect a change in their behavior because courts have ruled that there is no private right of action against nursing homes for failing to comply with the Medicaid care requirements. Prince v. Dicker, No. 01-7805, 2002 WL 226492, at *2 (2d Cir. Feb. 14, 2002); Brogdon v. Nat'l Healthcare Corp., 103 F. Supp. 2d 1322, 1330–32 (N.D. Ga. 2000); Estate of Ayres *ex rel.* Strugnell v. Beaver, 48 F. Supp. 2d 1335, 1339–40 (M.D. Fla. 1999); Nichols v. St. Luke Ctr. of Hyde Park, 800 F. Supp. 1564, 1567–68 (S.D. Ohio 1992). Therefore, Medicaid patients must use an indirect approach of suing the Secretary and the states.

41. *E.g.*, *In re* Estate of Smith v. Heckler, 747 F.2d 583, 588, 590 (10th Cir. 1984) (challenging the federal regulation of nursing homes as being "facility oriented" rather than "patient oriented," and therefore resulting in only "paper compliance"); Linton *ex rel.* Arnold v. Comm'r of Health & Env't, 779 F. Supp. 925, 932–33, 936 (M.D. Tenn. 1990) (challenging racial discrimination committed by the state of Tennessee through its policy of limiting the number of Medicaid beds in nursing homes, which delayed African Americans transfer to nursing homes).

Medicaid Act's[42] "reasonable promptness" provision and the Nursing Home Reform Act's (NHRA)[43] requirements for the provision of care.[44] Under the Medicaid Act, the Secretary and the states are required to ensure that Medicaid patients receive reasonably prompt medical assistance, which includes nursing home care.[45] Furthermore, the NHRA mandates that the Secretary and the states 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 . . . ."[46] If the care does not comply with the Medicaid Act or the NHRA, then the Secretary and the states are required to discipline the nursing home. At present, despite empirical data[47] and government

42. Although Medicaid pays for the majority of nursing home care, Medicare also pays for nursing home services. ELLEN O'BRIEN, GEORGETOWN UNIV., MEDICAID'S COVERAGE OF NURSING HOME COSTS: ASSET SHELTER FOR THE WEALTHY OR ESSENTIAL SAFETY NET? 1 fig.1 (2005), *available at* http://ltc.georgetown.edu/pdfs/nursinghomecosts.pdf (noting Medicaid is by far the largest payer at over forty-five percent, with Medicare making about twelve percent of the payments). The focus of this Article is on Medicaid and the Nursing Home Reform Act (NHRA) because courts have ruled that the statutory language of these Acts provide rights-creating language necessary to sustain a § 1983 claim. *See infra* Part IV.A.

43. The NHRA was enacted as part of the Omnibus Budget Reconciliation Act of 1987. Pub. L. No. 100-203, §§ 4201–4218, 101 Stat. 1330, 1330-160 to -221 (codified at 42 U.S.C. §§ 1395i-3, 1396r (2006 & West. Supp. 2009)). The NHRA required HHS to revamp the entire nursing home regulatory framework to cure the perceived quality of care downfalls of nursing homes. *See* David A. Bohm, *Striving for Quality Health Care in America's Nursing Homes: Tracing the History of Nursing Homes and Noting the Effect of Recent Federal Government Initiatives to Ensure Quality Care in the Nursing Home Setting*, 4 DEPAUL J. HEALTH CARE L. 317, 331–37 (2001). The NHRA changed the regulation of nursing homes from a review of their capacity to provide "facility oriented" care to whether the nursing home actually provided quality "patient oriented" care. *Heckler*, 747 F.2d at 590–91. Even though the NHRA was incorporated into the Medicaid Act in several places, including 42 U.S.C. § 1396r, plaintiffs still bring claims against the government based on the NHRA provisions and courts have ruled that the NHRA grants private parties rights against the government. *See* Rolland v. Romney, 318 F.3d 42, 51–56 (1st Cir. 2003) (ruling that several portions of § 1396r, including subsection (b), provide a private right of action under § 1983); Joseph S. v. Hogan, 561 F. Supp. 2d 280, 300–03 (E.D.N.Y. 2008) (ruling that § 1396r(e)(7) provided a private right of action under § 1983). Thus, because some courts still treat the NHRA as a separate regulatory law, even though the NHRA has been incorporated into the Medicaid Act, I refer to the NHRA separately from other Medicaid requirements regarding access to nursing home care.

44. Although these class action suits are discussed in terms of African American patients, all Medicaid patients, regardless of race, can use the Medicaid Act to challenge governmental failures in providing reasonably prompt access to quality health care. *See infra* notes 382, 398–401 and accompanying text. I have proposed this solution for only African Americans because currently the empirical data has primarily focused on racial inequities in care under Medicaid. *See, e.g.*, Mor et al., *supra* note 25, at 235–38 (discussing the discrepancy among African Americans in Medicaid-concentrated "lower-tier" facilities). If there are state-specific data available regarding the delay of transfer, denial of admission, and disparities in quality of care provided to Medicaid patients versus other patients, then Medicaid patients in that state could use this solution to obtain an equitable remedy. *See infra* notes 385–88.

45. 42 U.S.C. §§ 1396a(a)(8)–(10), 1396d(a)(4) (2006 & West Supp. 2009).

46. *Id.* § 1396r(b)(2).

47. *See* Susan L. Ettner, *Do Elderly Medicaid Patients Experience Reduced Access to Nursing Home Care?*, 12 J. HEALTH ECON. 259, 278–79 (1993) (indicating an extended wait time for Medicaid

reports[48] showing that elderly African Americans are not provided with reasonably prompt access to quality nursing home care as required by Medicaid and the NHRA, neither the Secretary nor the states have disciplined guilty nursing homes.[49]

In addition to providing evidence of governmental failures to comply with the dictates of Medicaid and the NHRA in the proposed legal actions, African Americans will have to show that Medicaid and the NHRA provide a private right of action under § 1983.[50] Several circuits have already ruled that the "reasonable promptness" provision[51] and the NHRA[52] provide a private right of action under 42

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patients over private-placement patients); Falcone & Broyles, *supra* note 6, at 591 (discussing study results that indicate that non-Caucasian patients experience longer discharge delays than Caucasian patients, even when controlled for other factors); David J. Falcone & Robert Broyles, *What Types of Hospital Patients Wait for Alternative Placement? Findings from an Exploratory Case Study and Policy Implications*, 5 J. AGING & SOC. POL'Y, Apr. 1994, at 77, 77–98 (providing interim a data report on delayed discharge); David Falcone et al., *Waiting for Placement: An Exploratory Analysis of Determinants of Delayed Discharge of Elderly Hospital Patients*, 26 HEALTH SERVICES RES. 339, 357–58, 367 (1991) (highlighting race as a factor in delayed discharge from hospital to nursing home); Smith, *supra* note 6, at 859–61 (discussing results of a study showing that Caucasians have better access to higher quality facilities).

48. *See* HEALTH CARE CHALLENGE, *supra* note 18, at 6–9, 73–74, 78–80, 203–04 (highlighting discrepancies based on race in the prompt delivery of health care services); MINORITY ELDER ACCESS, *supra* note 25, at 3–6 (noting the difficulties facing African Americans seeking access to health care in New York State); Sylvia Drew Ivie, Exec. Dir., Nat'l Health Law Program, Statement Before the U.S. Commission on Civil Rights: Minorities and Access to Health Care, *in* CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY 29, 32 (1980) (describing the difficulties that minorities face in accessing health care).

49. *See infra* Part II.

50. *See* Blessing v. Freestone, 520 U.S. 329, 340–41 (1997) (explaining requirements for showing that there is a private right of action under § 1983). With the passage of the Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006), some scholars have questioned the viability of Medicaid claims under 42 U.S.C. § 1983. *E.g.*, Jon Donenberg, Note, *Medicaid and Beneficiary Enforcement: Maintaining State Compliance with Federal Availability Requirements*, 117 YALE L.J. 1498, 1503 (2008). However, others have argued that the Deficit Reduction Act of 2005 did not in any way affect this right. *E.g.*, Harper Jean Tobin & Rochelle Bobroff, *The Continuing Viability of Medicaid Rights After the Deficit Reduction Act of 2005*, 118 YALE L.J. POCKET PART 147, 147–48 (2009). To date no court has ruled that the Deficit Reduction Act of 2005 barred Medicaid claims under 42 U.S.C. § 1983. *Id.* at 148.

51. *See* Doe v. Kidd, 501 F.3d 348, 355–56 (4th Cir. 2007) (ruling that there was a private right of action under § 1983 in 42 U.S.C. § 1396a(a)(8)); Watson v. Weeks, 436 F.3d 1152, 1159 (9th Cir. 2006) (ruling that there was a private right of action under § 1983 in 42 U.S.C. § 1396a(a)(10)); Sabree *ex rel.* Sabree v. Richman, 367 F.3d 180, 192–94 (3d Cir. 2004) (same); S.D. *ex rel.* Dickson v. Hood, 391 F.3d 581, 601, 603–07 (5th Cir. 2004) (same); Bryson v. Shumway, 308 F.3d 79, 89 (1st Cir. 2002) (ruling that there is a private right of action under § 1983 in 42 U.S.C. § 1396a(a)(8)). *But see* Sanders *ex rel.* Rayl v. Kan. Dep't of Soc. & Rehab. Servs., 317 F. Supp. 2d 1233, 1250–51 (D. Kan. 2004) (finding that the "reasonable promptness" provision does not provide a private right under § 1983); M.A.C. v. Betit, 284 F. Supp. 2d 1298, 1307–08 (D. Utah 2003) (same).

52. *See* Grammer v. John J. Kane Reg'l Ctrs.-Glen Hazel, 570 F.3d 520, 522, 525, 532 (3d Cir. 2009) (ruling that NHRA § 1396r(b) provided a private right of action under § 1983); Joseph S. v. Hogan, 561 F. Supp. 2d 280, 299–303 (E.D.N.Y. 2008) (ruling that NHRA § 1396r(e)(7) provided a private right of action under § 1983); Rolland v. Romney, 318 F.3d 42, 51–56 (1st Cir. 2003) (ruling that several sections of NHRA, including 42 U.S.C. § 1396r(b), provide a private right of action under

U.S.C. § 1983. Based on precedent, African Americans have a private right of action against the Secretary and the states for violation the Medicaid Act and the NHRA.

Overall, elderly African Americans have a strong case against the Secretary and the states because they have a duty to provide reasonably prompt access to quality nursing home care that they have breached and § 1983 provides African Americans a private right of action to redress this breach. Although these lawsuits can be costly and time consuming, they have the power to transform the broken civil rights system by inducing the government to fix the problem of racial discrimination in health care.

I. EMPIRICAL DATA OF RACIAL INEQUITIES DUE TO RACIAL DISCRIMINATION

Medicaid is a joint federal and state partnership, which the states administer.[53] The purpose of the Medicaid Act is to grant reasonable access to those "whose income and resources are insufficient to meet the costs of necessary medical services, and . . . rehabilitation and other services . . . ."[54] Originally drafted to provide health care to poor children and families, Medicaid is now the largest payer of long-term care services for the elderly.[55] Medicaid eligibility for the elderly differs significantly by state, but once a patient qualifies for Medicaid, the state will pay for nursing home services without any day limits.[56] Nursing home care accounts for 16.6% of all Medicaid spending.[57]

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§ 1983). *But see* Sparr v. Berks County, No. CIV.A. 02-2576, 2002 WL 1608243, at *1–*3 (E.D. Pa. July 18, 2002) (summarily finding no private right of action under NHRA § 1396r).

53. 42 U.S.C. §§ 1396, 1396a(a)(1)–(2), (5) (2006 & West Supp. 2009).

54. 42 U.S.C. § 1396 (2006).

55. Although, in 2006, Medicaid only paid for 43.4% of nursing home care, it provided payment for 64.8% of all nursing home residents. HEALTH, UNITED STATES, 2008, *supra* note 24, at 129; CHARLENE HARRINGTON ET AL., UNIV. OF CAL., S.F., NURSING FACILITIES, STAFFING, RESIDENTS AND FACILITY DEFICIENCIES, 2001 THROUGH 2007, at 18 (2008), *available at* http://www.pascenter.org/documents/OSCAR2007.pdf. *See also* O'BRIEN, *supra* note 42, at 1–2 (noting that although Medicaid was originally crafted for poor Americans, it is now used to pay for the long-term care of many middle-income and wealthy elderly); Charlene Harrington et al., *Nurse Staffing Levels and Medicaid Reimbursement Rates in Nursing Facilities*, 42 HEALTH SERVICES RES. 1105, 1106 (2007) ("Medicaid pays for [sixty-seven] percent of all nursing home residents in the United States . . . .").

56. For a detailed discussion concerning qualifying for Medicaid, see KAISER COMM'N ON MEDICAID AND THE UNINSURED, PAYING FOR NURSING HOME CARE: ASSETS TRANSFER AND QUALIFYING FOR MEDICAID (2006), *available at* http://www.kff.org/medicaid/upload/7452.pdf. *See also* KAISER FAMILY FOUND., STATE VARIATION & HEALTH REFORM: A CHARTBOOK 9 (2009), *available at* http://facts.kff.org/chartbooks/State%20Variation%20and%20Health%20Reform.pdf (showing that eligibility for Medicaid varies by state); Sandra Tanenbaum, *Medicaid and Disability: The Unlikely Entitlement*, 67 MILBANK Q. 288, 302 (1989) (indicating that if a beneficiary requires a "nursing home level of care," then that beneficiary is not subject to any day limits).

57. CTRS. FOR MEDICAID & MEDICARE SERVS., NATIONAL HEALTH EXPENDITURES BY TYPE OF SERVICE AND SOURCE OF FUNDS: CALENDER YEARS 1960-2008. Medicaid provides reimbursement for

Nursing homes remain the central institutional provider of care for the elderly and disabled,[58] although some elderly and disabled patients now reside in other long-term care facilities including assisted living facilities[59] and continuing care retirement communities.[60] In 2004, nursing homes provided care to 1.5 million elderly and disabled persons, with the average length of stay being 835 days.[61] By 2050, nursing homes are projected to provide care to 6.6 million elderly and disabled persons.[62] African Americans' used nursing homes 14% more than Caucasians' in 2000.[63] This disparity in the growth of African Americans needing nursing home care is projected to grow for several reasons.

First, 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 90%.[64] Second, many Caucasians no longer reside in nursing homes in part because of the creation of new long-term care service providers. Studies show that

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nursing home care for indigent elderly and affluent elderly and disabled patients that spend down their resources. *See* O'BRIEN, *supra* note 42, at 1–2.

58. *See* WAN HE ET AL., U.S. DEP'TS OF HEALTH & HUMAN SERVS. & COMMERCE, PUB. NO. P23-209, CURRENT POPULATION REPORTS: 65+ IN THE UNITED STATES: 2005, at 67 (2005), *available at* http://www.census.gov/prod/2006pubs/p23-209.pdf ("Over [ninety] percent of institutionalized older people live in nursing homes . . . .").

59. "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." Admin. on Aging, Nat'l Insts. of Health, Assisted Living, http://www.nlm.nih.gov/medlineplus/assistedliving.html (last visited June 14, 2010).

60. According to the Centers for Medicare and Medicaid Services:

> 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 MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., PAYING FOR LONG TERM CARE: CONTINUING-CARE RETIREMENT COMMUNITIES, http://www.medicare.gov/LongTermCare/Static/ContinuingCare.asp?dest=NAV%7CPaying%7CHomeEquity%7CContinuingCare#TabTop (last visited June 14, 2010).

61. ADRIENNE L. JONES ET AL., CTRS. FOR DISEASE CONTROL AND PREVENTION, DHHS PUB. NO. PHS-2009-1738, THE NATIONAL NURSING HOME SURVEY: 2004 OVERVIEW, 1, 4, 19 tbl.7 (2009), *available at* http://www.cdc.gov/nchs/data/series/sr_13/sr13_167.pdf. The 2004 survey of nursing homes in the United States revealed that there were 16,100 nursing homes with an occupancy rate of 86.3%. *Id.* at 1, 14 tbl.1.

62. AM. HEALTH CARE ASS'N, FACTS AND TRENDS: THE NURSING FACILITY SOURCEBOOK 5 (2001), *available at* http://www.ahcancal.org/research_data/trends_statistics/Documents/Nursing_Facility_Sourcebook_2001.pdf; Encyclopedia of Am. Indus., SIC 8051 Skilled Nursing Care Facilities, http://www.referenceforbusiness.com/industries/Service/Skilled-Nursing-Care-Facilities.html (last visited June 14, 2010).

63. 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, 871 (2008).

64. 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).

"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.[65] The siphoning off of Caucasians has created an excess nursing-home capacity that nursing homes filled with African American patients.[66] Third, even after adjusting for income differences, the burden of disability falls heaviest on elderly minorities.[67]

Born and raised during the Jim Crow era of legalized racial discrimination, elderly African Americans have lacked equal access to health care services for most of their lives, and thus are more disabled than Caucasians.[68] Hence, the growth in the elderly African American population will mean more African Americans need access to nursing home services.[69] However, two decades of empirical studies suggest that there is a well-developed pattern and practice of racial inequities in the provision of quality nursing home care.[70] Specifically, African Americans receive unequal access to quality nursing home services as a result of transfer delays from hospitals,[71] admission to poor quality nursing homes,[72] and racial inequities in the provision of quality nursing home care.[73]

A. Delay of Access to Nursing Home Services in a Reasonably Prompt Manner

Scholars have defined access to health care "as those dimensions [that] describe the potential and actual entry of a given population group to the health

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65. Smith et al., *supra* note 63, at 876.

66. *Id.*

67. *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). "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 . . . ." Sylvia Drew Ivie, Ending Discrimination in Health Care: A Dream Deferred, *in* CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY, *supra* note 48, at 282, 292.

68. *See generally* Andrea Patterson, *Germs and Jim Crow: The Impact of Microbiology on Public Health Policies in Progressive Era American South*, 42 J. HIST. BIOLOGY 529, 529–59 (2009) (discussing how the denial of access to health care as a consequence of the Jim Crow laws caused blacks to have more health problems ranging from the acquisition of germs to life and death situations); Robert A. Hummer et al., *Racial and Ethnic Disparities in Health and Mortality Among the U.S. Elderly Population*, *in* CRITICAL PERSPECTIVES ON RACIAL AND ETHNIC DIFFERENCES IN HEALTH IN LATE LIFE 53, 64–69 (Norman B. Anderson et al. eds. 2004) (stating that African Americans and Native Americans "exhibit the highest levels of disability at each age group among the elderly").

69. *See* Fennell et al., *supra* note 6, at 175 (noting the projected growth of elderly non-Caucasions and African Americans' lack of access to nursing home care); Wallace, *supra* note 8, at 673–76 (noting a persistent difference between the proportion of older African Americans and Caucasions who use nursing homes).

70. *See* Falcone & Broyles, *supra* note 6, at 588–92 (noting racial disparities in discharge delay); Weissert & Cready, *supra* note 6, at 632, 642 (noting discrepant treatment between races in nursing home admissions).

71. Falcone & Broyles, *supra* note 6, at 591–92; Weissert & Cready, *supra* note 6, at 632, 642.

72. Smith et al., *supra* note 63, at 871; Lowenstein, *supra* note 17.

73. Mor et al., *supra* note 25; Lowenstein, *supra* note 17.

care delivery system."[74] Inequity in access occurs when "services are distributed on the basis of demographic variables such as one's race, level of income, or where one lives" instead of being distributed based on medical need.[75] In turn, such inequities in access to "health care manifests itself in many ways, affecting both the quality and longevity of life."[76]

More specifically, the significant manifestations of inequities in access to nursing homes are transfer delays from hospitals.[77] Nearly half of elderly patients are transferred to a nursing home after a hospital stay.[78] The decision to transfer a patient from a hospital to a nursing home is controlled by the patient's physician and the hospital's discharge staff.[79] A transfer normally occurs once a physician determines that a patient is well-enough to be released from the hospital, but not well-enough to go home. A member of the hospital discharge staff seeking to transfer a patient contacts the nursing home.[80]

A delay in transfer is "the time elapsed between when a patient was medically ready for discharge" to another form of care "and when he or she actually was discharged."[81] Delays in transfers to nursing homes have a direct impact on the patient's well-being by denying patient's access to medically necessary rehabilitative care, which hospitals are not equipped to provide.[82] Non-Caucasians are often delayed in transfer to quality nursing homes.[83]

Since the 1980s, studies have shown that African Americans are delayed by at least ten days in a transfer from the hospital to a nursing home.[84] Statistical analysis

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74. Lu Ann Aday, Sr. Res. Assoc., Ctr. for Health Admin. Studies, Univ. of Chi., Statement Before the U.S. Commission on Civil Rights: Selected Aspects of a National Study of Access to Medical Care, *in* CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY, *supra* note 48, at 19, 20.

75. *Id.*

76. HEALTH CARE CHALLENGE, *supra* note 18, at 3.

77. Falcone & Broyles, *supra* note 6, at 591–92 (noting racial disparities in discharge delay); Weissert & Cready, *supra* note 6, at 632, 642 (noting race-based discrepancies in transfer delays).

78. National statistics show "[a]bout 32 percent entered from a private residence, 45 percent were admitted from a hospital, and about 12 percent were admitted from another nursing home." HE ET AL., *supra* note 58, at 68.

79. *See* MINORITY ELDERLY ACCESS, *supra* note 25, at 18–19 (discussing the use of "discharge planners" in hospitals who steer patients to nursing homes).

80. *See* Collaboration Between Nursing Homes and Health System: Hospital to Nursing Home Issues, http://www.medscape.com/viewarticle/487323_3 (last visited Apr. 11, 2010) (discussing telephone communication as a means facilitating the transition process).

81. *See* Falcone & Broyles, *supra* note 6, at 584.

82. *See id.* at 592–93 (noting discharge delays have consequences for quality by providing sub-optimal situations for frail elderly).

83. MINORITY ELDERLY ACCESS, *supra* note 25, at 19; Falcone & Broyles, *supra* note 6, at 588–92; Weissert & Cready, *supra* note 6, at 645.

84. *E.g.*, Falcone & Broyles, *supra* note 6, at 585, 589 tbl.3 (reporting an average delay of 10.7 days for the general population, eight days for Caucasians, and twenty days for non-Caucasians); *see also* Ettner, *supra* note 47, at 260, 278 (noting that patients who rely primarily on Medicaid wait longer for a nursing home placement, impeding the care of certain subgroups of the population).

of transfer data suggests that African Americans' failure to find prompt nursing home placements did not correlate with the patient's payment source, physical condition, demographic attributes, family cooperativeness, or behavioral issues.[85] Instead, race was the central factor in the timing of transfer of patients from the hospital to a nursing home.[86] Thus, scholars have attributed the delay in transfer to racial discrimination.[87]

According to the authors of the study, Professors David Falcone and Robert Broyles, the fact that race is the greatest predictor of delay in transfer and that there has been no change in this delay even once brought to the attention of those responsible for transfers proves that racial discrimination is the cause of the delays.[88] Further research shows that because there are fewer African Americans in nursing homes than Caucasians,[89] African American patients are delayed transfer to nursing homes until they can be placed in the same room with other African Americans or can be transferred to predominantly African American nursing homes.[90] Hence, racial discrimination is also present in the admission practices and policies of nursing homes.

B. Denial of Admission to Quality Nursing Homes

Empirical studies conducted in New York and North Carolina suggest that African Americans experience delays in transfer to quality nursing homes because they are denied admission to quality nursing homes based on their race.[91] The racial inequities in nursing home admissions practices are significant because where a patient is admitted usually determines the quality of care that patient receives.[92]

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85. Falcone & Broyles, *supra* note 6, at 591 (asserting race-based reasons for the discrepancy).

86. *See id.* at 584, 591–92 (asserting that, with all other factors removed, racial discrimination must be the cause of delay).

87. *E.g.*, *id.*

88. *See* Falcone & Broyles, *supra* note 6, at 591–93 ("By default . . . the only explanation for the longer delays of [non-Caucasians] is the preference of nursing home owners or operators for [Caucasian] patients (that is, discrimination).").

89. Wallace, *supra* note 8, at 676–77.

90. Weissert & Cready, *supra* note 6, at 632, 642.

91. *See* MINORITY ELDERLY ACCESS, *supra* note 25, at 49 ("[Based on] two factfinding meetings . . . and information gathered through additional research, . . . it [is] reasonable to suspect that in New York State, discrimination on the basis of race plays a role in the rejection of at least some minorities by the nursing homes to which they apply for long-term care."); Falcone & Broyles, *supra* note 6, at 584, 588–92 (discussing delays in transfer in North Carolina nursing homes); Ronald Sullivan, *New Rules Sought on Nursing Homes*, N.Y. TIMES, May 5, 1985, at 146 [hereinafter Sullivan, *New Rules Sought*] (discussing a recommendation to require nursing homes to keep a record of accepted and rejected patients in order to determine whether segregation is deliberate); Ronald Sullivan, *Study Charges Bias in Admission to Nursing Homes*, N.Y. TIMES, Jan. 28, 1984, at 127 [hereinafter Sullivan, *Study Charges Bias*] (explaining that in New York, racial minority groups tend to be excluded from more desirable nursing homes).

92. *See* David C. Grabowski, *The Admission of Blacks to High-Deficiency Nursing Homes*, 42 MED. CARE 456, 456–60 (2004) (explaining the results of a study showing that on average, racial

In 1984, a study of New York nursing homes showed that nursing homes, which provided excellent quality of care demonstrated a pattern of admitting Caucasians over African Americans.[93] The study was based on civil rights documents submitted by nursing homes to the New York State Health Department.[94] According to the report Caucasian patients were admitted to quality nursing homes and those in racial minority groups were relegated to substandard[95] quality nursing homes.[96] Similar to the real estate industry, this inequity was attributed to "a combination of discrimination by nursing homes and steering by hospital discharge planners."[97]

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minorities are admitted to nursing homes with more quality-of-care deficiency citations compared to Caucasians).

93. Sullivan, *Study Charges Bias*, *supra* note 91; *see also* Sullivan, *New Rules Sought*, *supra* note 91 (noting that a member of a New York State task force explained that "[t]here is evidence of segregation in New York nursing homes").

94. Sullivan, *Study Charges Bias*, *supra* note 91.

95. Substandard quality of care means that the facility has one or more deficiencies related to the Medicaid regulations regarding resident behavior and facility practices, quality of life, or quality of care that constitutes "immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm." *See* 42 C.F.R. § 488.301 (2009).

96. Sullivan, *Study Charges Bias*, *supra* note 91; *see also* Wallace, *supra* note 8, at 677 (describing a study showing "a clear pattern of racial discrimination by the more desirable nursing homes in [New York City]"); Sullivan, *New Rules Sought*, *supra* note 91 (describing evidence of segregation in New York nursing homes).

97. Wallace, *supra* note 8, at 677. This practice of steering is common in the real estate industry. *See generally* CHARLES S. AIKEN, THE COTTON PLANTATION SOUTH SINCE THE CIVIL WAR 320–27 (1998) (discussing post-civil war federal financing of housing and the concentration of black residents on the fringes of municipalities); STEPHEN GRANT MEYER, AS LONG AS THEY DON'T MOVE NEXT DOOR: SEGREGATION AND RACIAL CONFLICT IN AMERICAN NEIGHBORHOODS 6 (2000) ("Realtors . . . convinced [Caucasian] home owners that property values would decline if African Americans moved in next door."); ANDREW WIESE, PLACES OF THEIR OWN: AFRICAN AMERICAN SUBURBANIZATION IN THE TWENTIETH CENTURY 207–08, 257 (2004) (discussing the separate suburbanization of African American communities and Caucasian communities and the development of subdivisions designed for African American families); Michael B. de Leeuw et al., *The Current State of Residential Segregation and Housing Discrimination: The United States' Obligations Under the International Convention on the Elimination of All Forms of Racial Discrimination*, 13 MICH. J. RACE & L. 337, 369–71 (2008) (describing the practice of real estate steering and tests that show its prevalence); George Galster & Erin Godfrey, *By Words and Deeds: Racial Steering by Real Estate Agents in the U.S. in 2000*, 71 J. AM. PLANNING ASS'N 251, 251–54 (2005) (discussing the historically common practice of steering and the types, mechanisms, and scale of the practice); john a. powell, *Reflections on the Past, Looking to the Future: The Fair Housing Act at 40*, 41 IND. L. REV. 605, 612–13 (2008) (describing how the process of real estate steering may occur and that its occurrence appears to have increased recently). The Supreme Court has defined *racial steering* in the real estate industry as:

> [A] practice by which real estate brokers and agents preserve and encourage patterns of racial segregation . . . by steering members of racial and ethnic groups to buildings occupied primarily by members of such racial and ethnic groups and away from buildings and neighborhoods inhabited primarily by members of other races or groups.

Havens Realty Corp. v. Coleman, 455 U.S. 363, 366 n.1 (1982).

In 1992, the New York State Advisory Committee to the U.S. Commission on Civil Rights (Advisory Committee) reviewed nursing home admission practices in New York and found that there were still significant racial inequities in admission between African Americans and Caucasians.[98] The Advisory Committee's findings showed that Caucasian patients were three times more likely to get into a quality nursing home than minority patients.[99]

Of the characteristics used to decide whether to admit a patient, race remained the chief factor, even in nursing homes sponsored by religious organizations, which were more likely to admit those of a different religious background than those of a different race.[100] Based on this evidence, the Advisory Committee found that "discrimination on the basis of race plays a role in the rejection of at least some minorities by the nursing homes to which they apply for long-term care."[101]

In 1988, Drs. William Weissert and Cynthia Cready found that there was a significant delay in transfer of African Americans from hospitals to nursing homes in North Carolina.[102] The authors suggested that this delay was because some Caucasian nursing home residents wanted to room with those of the same race.[103] To comply with this request, nursing homes intentionally kept rooms and their facility segregated by denying admittance to African Americans.[104] Denied access to quality nursing homes, African Americans are relegated to poor-performing nursing homes, resulting in inequities in quality in the provision of nursing home care.

Although these studies were conducted in the 1980s and 1990s, there is no evidence that race-based admission decisions have stopped.[105] Since the publication

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98. *See generally* MINORITY ELDERLY ACCESS, *supra* note 25, at 5 ("[M]inorities are in fact discriminated against in admissions to nursing homes here in New York State . . . .").

99. *Id.* at ii–iii; Sullivan, *Study Charges Bias*, *supra* note 91; Sullivan, *New Rules Sought*, *supra* note 91.

100. *See* MINORITY ELDERLY ACCESS, *supra* note 25, at 37–38 (citing Jeffrey Amber, Executive Director of Friends and Relatives of the Institutionalized Aging) (explaining a report that argued that many religious-based nursing homes would "accept [Caucasian] applicants from other religions but exclude minority people").

101. *Id.* at iii.

102. Weissert & Cready, *supra* note 6, at 642, 645.

103. *See id.* at 645 (attributing delays based on race, in part, to "nursing home policies of matching patients in semiprivate rooms on race or sex in combination with the low prevalence of [non-Caucasians] and males in the homes").

104. *Id.*

105. *See* Smith et al., *supra* note 63, at 876 (explaining a recent research study that showed that changes in hospital policies and shifts in payment incentives in the mid-1980s have led to an increase in African Americans' use of nursing homes); Grabowski, *supra* note 92, at 462 (noting, in 2004, that an explanation for the finding that African Americans are admitted to nursing homes with greater deficiencies is potential discriminatory practices by the facilities in admission decisions). Because of the financial burden on hospitals from transfer delays of elderly African Americans, "[h]ospitals hired full-time discharge planners, acquired or built nursing homes or short-stay long-term-care units, and engaged in a variety of partnerships with long-term-care chains to reduce the placement problems for which they

of these studies, research studies have focused on the provision of care provided after patients are admitted to nursing homes,[106] which is easier to track.[107] This shift in research is due to the availability of new governmental data that allows researchers to track racial inequities in the provision of quality nursing home care once patients are admitted.[108] Based on governmental data, these studies suggest that racial inequities in the provision of quality nursing home care persist.[109]

C. Inequities in the Quality of Nursing Home Care Provided to African Americans

The quality of nursing home care is defined by the care provided to residents and the health of the residents after admission to the nursing home. These factors determine whether a nursing home is in compliance with the Medicaid conditions

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now received no reimbursement." Smith et al., *supra* note 69, at 876. However, this study only reviewed use data, which does not provide information regarding delays in transfer. *Id.* at 867. Furthermore, in the 1990s, after the implementation of changed hospital polices and shifts in payment incentives, two lawsuits were filed regarding delays in transfer to nursing homes. *See* Taylor v. White, 132 F.R.D. 636, 639–40 (E.D. Pa. 1990) (challenging the delay in transfer to nursing homes and the poor quality of care provided African Americans in Philadelphia nursing homes); Linton *ex rel.* Arnold v. Comm'r of Health & Env't, 779 F. Supp. 925, 927–28 (M.D. Tenn. 1990) (challenging racial discrimination committed by the state of Tennessee through its policy of limiting the number of Medicaid beds in nursing homes). In *Linton ex rel. Arnold*, the court ordered Tennessee to change its polices. 779 F. Supp. at 935.

106. *See, e.g.*, Smith et al., *supra* note 8, at 1450 (explaining a recent study describing racial segregation in nursing homes and its relationship to disparities in quality of care); Grabowski, *supra* note 92, at 457 (describing a study that focused on "quality of care at the time of nursing home entry" in order to examine "potential racial and ethnic differences in the nursing home selection and admission process").

107. *See* Smith et al., *supra* note 8, at 1449–50 (discussing the lack of data and documentation of minorities' access to high-quality nursing home care); Agency for Healthcare Research & Quality, U.S. Dep't of Health & Human Servs., National Healthcare Quality & Disparities Reports, http://nhqrnet.ahrq.gov/nhqrdr/jsp/nhqrdr.jsp (last visited June 14, 2010) (containing data on quality of care in nursing homes); Am. Health Care Ass'n, OSCAR Data, http://www.ahcancal.org/research_data/oscar_data/Pages/default.aspx (last visited June 14, 2010) (providing data of inspection surveys for the purpose of certification for participation in Medicare and Medicaid).

108. *See, e.g.*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., AHRQ PUB. NO. 03-P004, NATIONAL HEALTHCARE QUALITY REPORT: UPDATE ON CURRENT STATUS (2002), *available at* http://www.ahrq.gov/qual/nhqrfact.pdf (documenting healthcare quality); Agency for Healthcare Research & Quality, *supra* note 107 (website where data on quality of care in nursing homes can be found); Am. Health Care Ass'n, *supra* note 107 (website with OSCAR data). Congress established the Agency for Healthcare Research and Quality in 1999, requiring it to "develop databases and tools that provide information to States on the quality, access, and use of health care services provides to their residents." Healthcare Research and Quality Act of 1999, Pub. L. No. 106-129 sec. 2(a), §§ 901(a), 913(a)(2), 113 Stat. 1653, 1653, 1658.

109. *See* Smith et al., *supra* note 8, at 1450–53 (explaining a study showing racial disparities using data collected from the Centers for Medicare and Medicaid Services Online Survey Certification and Reporting System).

of participation.[110] If a nursing home is significantly out of compliance with the Medicaid conditions of participations, then it can be deemed substandard.[111]

Substandard care is defined as a significant deficiency in care that caused actual or serious actual harm to one or more nursing home residents.[112] Substandard care often results from the failure to provide care to residents, such as the failure to prevent pressure sores or falls.[113] A plethora of research studies have noted racial inequities in the provision of quality nursing home care.[114] For example, national data compiled from Medicare forms showed that African Americans reside in nursing homes with "lower ratings of cleanliness/maintenance and lighting . . . ."[115]

Another study of several states, including New York, Kansas, Mississippi, and Ohio, found that the quality of care provided Caucasians and African Americans is different.[116] African Americans usually receive poor quality care when compared to Caucasians. For example, the resident assessment instrument (RAI),[117] which includes racial data, showed that late-stage pressure sores are more common to African Americans, while early stage pressure sores are more common to Caucasians.[118] According to the researchers, the higher rates of late-stage pressure sores in African Americans occur because they are commonly underdiagnosed.[119] Hence, Caucasians received treatment before the pressure sore

110. 42 C.F.R. § 483.1(b) (2009). The conditions of participation used to review Medicaid certified nursing homes are the Medicare conditions of participation and state requirements. *Id.* §§ 483.1(b), 488.300. To prevent confusion, I have referred to these requirements as the Medicaid conditions of participation.

111. *Id.* § 488.301.

112. *Id.*

113. OFFICE OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. NO. OEI-02-01-00600, NURSING HOME DEFICIENCY TRENDS AND SURVEY AND CERTIFICATION PROCESS CONSISTENCY 22, 26, 28 (2003), *available at*: http://oig.hhs.gov/oei/reports/oei-02-01-00600.pdf (identifying "[p]roper treatment to prevent or treat pressure sores" and "falls among its residents" as categories of quality of care deficiencies); U.S. GEN. ACCOUNTING OFFICE, PUB. NO. GAO/T-HEHS-98-219, CALIFORNIA NURSING HOMES: FEDERAL AND STATE OVERSIGHT INADEQUATE TO PROTECT RESIDENTS IN HOMES WITH SERIOUS CARE VIOLATIONS 4–6 (1998) (explaining several deficiencies found in California nursing homes, including residents with pressure sores, weight loss, and a lack of necessary medication).

114. *E.g.*, Fennell et al., *supra* note 6, at 174; Grabowski, *supra* note 92, at 462; Mor et al., *supra* note 25, at 227–28; Smith, *supra* note 6, at 859–61.

115. Grabowski, *supra* note 92, at 456.

116. Fennell et al., *supra* note 6, at 178–80. 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.* at 174.

117. 42 C.F.R. § 483.20(b)(1) (2009). 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); CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T HEALTH & HUMAN SERVS., LONG-TERM CARE FACILITY RESIDENT ASSESSMENT INSTRUMENT USER'S MANUAL 2-4, 2-12, 5-2 (2009). 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. § 483.20(f); CTRS. FOR MEDICARE & MEDICAID SERVS., *supra*, at 5-1 to -2.

118. Fennell et al., *supra* note 6, at 175–76.

119. *Id.* at 176.

became too severe, while African Americans and other minorities suffered without treatment until the pressure sores became irreparable.[120] Manifested in many different ways and forms, poor quality care often translates into poor health outcomes for African Americans compared to Caucasians.[121]

A 2008 study consisting of data from 8,997 nursing homes located in urban cities throughout the continental United States[122] found that African American nursing home residents were more likely than Caucasian residents to be hospitalized for "dehydration, poor nutrition, bedsores and other aliments because of a gap in the quality of in-house medical care" in nursing homes.[123] These ailments arise when residents are not receiving proper care.[124] Researchers noted that of the 516,082 patients tracked, nineteen percent were hospitalized by the end of the 150-day follow-up period.[125] Of the nursing home residents hospitalized, twenty-four percent of African Americans were hospitalized, while only nineteen percent of Caucasians were hospitalized.[126] Thus, the health of African Americans residing in nursing homes is often poorer than Caucasians residing in nursing homes.

The quality of nursing home care is further assessed by nursing home compliance with Medicaid conditions of participation. The failure to comply with these conditions results in deficiencies.[127] In a recent national study of nursing home quality released in 2004, researchers deemed facilities whose primary source

120. *See id.* (explaining that late-stage pressure sores are more common in minorities compared to Caucasians).

121. *See infra* notes 122–26 and accompanying text.

122. 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).

123. Jackie Spinner, *Illness, Race Tied in Study of Care: Comparison Made at Nursing Homes*, WASH. POST, Jan. 15, 2008, at B1; *see also* Gruneir et al., *supra* note 122, at 877 (finding that African American residents are at greater risk of hospitalization than Caucasian residents).

124. *See Nursing Home Quality: Problems, Causes, and Cures: Testimony Before the S. Comm. on Fin.* 2 (2003) (written testimony of Catherine Hawes, Professor, Texas A&M Univ. Sys. Health Sci. Ctr.), *available at* http://finance.senate.gov/imo/media/doc/071703chtest.pdf (explaining that neglect by nursing home staff leads to undernutrition, malnutrition, and dehydration); OFFICE OF INSPECTOR GEN., *supra* note 113, at 8, 28 (explaining that deficiencies in treatment of pressure sores and provision of nutrition and hydration are included in categories related to "substandard quality of care").

125. Gruneir et al., *supra* note 122, at 871, 874.

126. *Id.* at 874. Additionally, the percentage of residents who had to be hospitalized strongly correlated with the states' Medicaid rate. *Id.* at 877. Increasing the Medicaid reimbursement rate by ten dollars reduced the odds of hospitalization by four percent for Caucasians and twenty-two percent for African Americans. *Id.* This suggests that race and Medicaid payment rates are inextricably linked.

127. 42 C.F.R. § 488.301 (2009). A deficiency or citation is a violation of the Medicaid conditions of participation requirements found in the program regulations. *Id.* § 483.1(b). There are a total of 190 possible Medicare deficiencies divided into seventeen different categories for which HHS can cite a nursing home. OFFICE OF INSPECTOR GEN., *supra* note 113, at 1. Most deficiencies are categorized into three main areas: quality of care, § 483.25; quality of life, § 483.15; and resident behavior and facility practice, § 483.13. OFFICE OF INSPECTOR GEN., *supra* note 113, at 8.

of payment is Medicaid as "lower-tiered facilities" because of their poor quality.[128] They found that African Americans are three to five times more likely to be in lower-tiered facilities than Caucasians.[129]

The placement of a majority of African Americans in lower-tiered facilities is significant because these nursing homes are more likely to be terminated from the Medicaid program because of substandard quality, though not for Title VI violations.[130] These lower-tiered facilities have fewer nurses, more quality of care deficiencies, higher incidences of pressure sores, use physical restraints more, and have inadequate pain control and use of antipsychotic medications.[131] Studies have shown that Caucasians reside in nursing homes with an average of 5.13 deficiencies, whereas African Americans reside in nursing homes with an average of 7.39 deficiencies.[132]

Additionally, an investigation by the *Chicago Reporter* of Illinois nursing homes showed that African Americans residing in nursing homes received poor quality care compared to Caucasians.[133] Of the fifty-one predominately African American nursing homes located in Illinois, there is just one rated "excellent" by the federal government.[134] These predominately African American facilities get the worst federal ratings for quality and on average have more deficiencies than facilities where a majority of residents are Caucasian.[135] In Chicago, a majority of the predominantly African American homes received "the worst rating—a one on a five-point scale— . . . compared with [eleven] percent of [Caucasian] nursing homes."[136] The investigation "also found that the staff at Illinois' [African American] nursing homes spent less time daily with residents than staff at facilities where a majority of the residents are [Caucasian]. Of that time, [African American] residents got a smaller percentage of time with more-skilled registered nurses than facilities where the residents were [Caucasian]."[137]

Overall, a review of the empirical data provides a dismal picture of the accessibility of quality nursing home care available to elderly African Americans. Three main barriers have been suggested to explain why racial inequities in health

128. Mor et al., *supra* note 25, at 227, 230.

129. *Id.* at 238 & fig.2. This ratio varies by state from zero to nine, and the only state where the ratio is zero is Kentucky. *Id.*

130. *Id.* at 234–35, 246.

131. *Id.* at 236, 239–40.

132. Grabowski, *supra* note 92, at 458.

133. Lowenstein, *supra* note 17 (explaining that predominantly African American nursing homes received low ratings more often than predominantly Caucasian nursing homes and that residents at the former received less staff time than those at the latter).

134. Jeff Kelly Lowenstein, *Lower Standards*, CHI. REP., July 1, 2009, *available at* http://www.chicagoreporter.com/index.php/c/Cover_Stories/d/Lower_Standards.

135. *Id.*

136. *Id.*

137. *Id.*

care persist: residential segregation,[138] socioeconomic status,[139] and racial discrimination.[140] It is clear from the literature that no one factor has been accepted as the central reason for the inequities. However, a review of the nursing home system and its problems suggests that racial discrimination is the central reason for racial inequities in accessing quality nursing home care.[141]

First, residential segregation in quality nursing homes was even greater than the residential segregation in the neighborhood.[142] Second, even when socioeconomic status was controlled, racial inequities in access to quality nursing homes persisted.[143] Finally, a review of the literature discussing the causes for residential segregation and socioeconomic status of African Americans identifies racial discrimination as one of the reasons for the continuation of the ills of African Americans.[144] If racial inequities in the quality of nursing home care are not caused by residential segregation or socioeconomic status, why is racial discrimination the culprit?

In sum, based on empirical research, race remains the central barrier to elderly African Americans accessing quality nursing home care. African Americans

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138. *See generally* Wallace, *supra* note 8, at 672–78 (determining that residential segregation affects the medical system because of its economic structure); Wallace et al., *supra* note 8, at S104–07 (analyzing the causes of racial differences in access to long-term care); Williams, *supra* note 8, at 177–80 (discussing residential segregation's impact on health through employment); Williams & Collins, *supra* note 8, at 404–05 (arguing that racial residential segregation is the cornerstone of disparities in heath status between African Americans and Caucasians).

139. *See generally* Jim Mitchell et al., *Difference by Race in Long-Term Care Plans*, 19 J. APPLIED GERONTOLOGY 424, 435–38 (2000) (reporting on the role of family care in long-term care plans of African Americans and Caucasians); Mor et al., *supra* note 25, at 227 (arguing that nursing home care is a two-tiered system); Nadereh Pourat et al., *Postadmission Disparities in Nursing Home Stays of Whites and Minority Elderly*, 12 J. HEALTH CARE FOR POOR & UNDERSERVED 352, 352–53, 362–63 (2001) (determining that a person's length of stay includes socio-cultural characteristics); Wallace, *supra* note 8, at 665–66, 672–78 (finding that employment patterns, retirement income, and health insurance differ for elderly African Americans as compared to Caucasians); Wallace et al., *supra* note 8, at S104 (stating that the need for long-term health care is higher for minorities considering their low socioeconomic status); Williams, *supra* note 8, at 177 (finding that racism restricts socioeconomic attainment for members of minority groups); Williams & Collins, *supra* note 8, at 406 (arguing that institutional discrimination affects income levels for minorities).

140. Based on the empirical data, researchers have argued that the actions of the nursing homes are blatantly and intentionally discriminatory. *See* Falcone & Broyles, *supra* note 6, at 588, 591–92 (finding that race affects patient delay in accessing nursing homes); Fennell et al., *supra* note 6, at 175 (determining that racial differences exist in both medical care and nursing home usage); Smith, *supra* note 6, at 861 (determining that nursing-home patient treatment is influenced by race); Weissert & Cready, *supra* note 6, at 645 (concluding that non-Caucasian patients faced longer delays than other patients).

141. *See infra* notes 142–49 accompanying text.

142. Fennell et al., *supra* note 6, at 175.

143. *See* Lowenstein, *supra* note 17 (finding that poverty only partially explained racial inequities in nursing homes).

144. Smith, *supra* note 6, at 862–64, 866; Smith et al., *supra* note 8, at 1456; Smith et al., *supra* note 63, at 861 (2008).

in North Carolina were delayed three to twelve days in transfer to nursing homes.[145] In Pennsylvania, elderly African Americans were delayed in transfer for months because they could not find a nursing home to accept them, and they had to reside in the hospital.[146] The delays in transfer result from a denial of admission to quality nursing homes because of race. Research studies in New York and North Carolina show that race remains the greatest predictor of accessing quality nursing home care.[147] Caucasian patients were three times more likely to be admitted to a quality nursing home than were African Americans.[148] Thus, based on this research, race remains the central factor in accessing nursing home care.

Although research studies of racial inequities in the provision of prompt, quality nursing home care have been limited to a small number of states, the studies conducted are paradigmatic of national practices as evidenced by civil rights complaints and reports. The Secretary and the states have been provided with the above-referenced research as well as civil rights complaints and reports, which show that some government-funded nursing homes continue to violate Title VI. However, little if anything has been done, as the next section details.[149]

II. CIVIL RIGHTS FAILURES IN HEALTH CARE

Since the passage of the Civil Rights Act of 1964, the United States has failed to put an end to racial discrimination in health care. This situation is due to statutory and regulatory failures.[150] Even though the statutory and regulatory language of Title VI provides a strong statement banning racial discrimination, it fails to provide meaningful sanctions for violators. Even if meaningful sanctions existed on paper, there is clear evidence that HHS and the states would still fail to adequately enforce Title VI.[151]

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145. Falcone & Broyles, *supra* note 6, at 588 tbl.3; Weissert & Cready, *supra* note 6, at 632.

146. Taylor v. White, 132 F.R.D. 636, 640 (E.D. Pa. 1990).

147. MINORITY ELDERLY ACCESS, *supra* note 25, at ii; Weissert & Cready, *supra* note 6, at 641, 645.

148. *See* MINORITY ELDERLY ACCESS, *supra* note 25, at ii–iii; Sullivan, *Study Charges Bias*, *supra* note 91 (revealing that in New York City, Caucasian patients tended to be accepted at better nursing homes while racial minorities were relegated to poorer ones); Sullivan, *New Rules Sought*, *supra* note 91 (same).

149. *See infra* Part II.

150. President Lyndon B. Johnson championed the Civil Rights Act, which was enacted in memorial to President Kennedy. SMITH, *supra* note 12, at 100. Although leading the charge for the enactment of the Civil Rights Act, President Johnson did not fully support all enforcement actions. For instance, during the passage of Title VI, Congress and the President noted that unlike hospitals, nursing homes were more than simple treatment centers. *Id.* at 159–61, 236–52. Nursing homes were viewed as private residences funded by the government. *Id.* at 159–60. In the 1960s, Congress and the President were unwilling to wage a massive attack to integrate these "homes." *Id.* Consequently, Title VI enforcement fell apart at the start because nursing homes were viewed as private homes of citizens. *Id.* at 159.

151. *See* HEALTH CARE CHALLENGE, *supra* note 18, at 6–9, 73–74, 203–04 (discussing how thus far, HHS has not sufficiently addressed the problem of minority access to quality health care).

As mandated by law, the U.S. Commission on Civil Rights (USCCR) reviewed the progress of HHS' Title VI enforcement in 1974, 1996, and 1999.[152] Each time the USCCR found that HHS was not fulfilling the mandates of Title VI.[153] There are multiple dimensions to this issue. Firstly, neither HHS nor USCCR monitor the states' enforcement of Title VI.[154] Secondly, the most recent studies conducted in New York and the lawsuits in Tennessee and Pennsylvania suggest that the states are also guilty of failing to enforce Title VI to prevent racial discrimination in health care. For example, the problems of racial inequities in admission and the provision of nursing home care were first presented to the New York state government in 1984.[155] Eight years later, a 1992 study completed by the New York State Advisory Committee to the USCCR showed that these same problems persisted.[156]

These federal and state governmental failures have spanned both Democratic and Republican administrations. Forty-five years after the enactment of Title VI, the time has come for the civil rights failures of the federal government and the states to be corrected.

A. Statutory Failures in Eradicating Racial Discrimination in Health Care

Offering the promise of equal access to quality heath care to African Americans, Title VI of the Civil Rights Act was doomed from the start. Section 602 of Title VI requires the federal government to ensure that entities receiving federal funding, such as nursing homes, do not discriminate on the basis of race, color, or national origin.[157] Although the language of Title VI clearly prohibits racial discrimination in health care by those receiving federal funding, the remedial scheme is ineffectual for two reasons.

First, under Title VI, the only remedy available to the government is termination from participation in government programs.[158] The USCCR has determined that when termination is the only government sanction, the trend has been for the government to try to avoid imposing termination by allowing nursing homes to voluntarily comply with the applicable regulations.[159] In fact, the regulations governing Title VI enforcement state that HHS is "to the fullest extent

152. *See* 42 U.S.C. § 2000d-1 (2006) (stating that the federal government will enforce nondiscrimination in federally assisted programs); FEDERAL TITLE VI ENFORCEMENT, *supra* note 29, at 1–2 (noting that the Commission monitored the federal agencies Title VI program periodically).

153. FEDERAL TITLE VI ENFORCEMENT, *supra* note 29, at 1–2.

154. *Id.* at 2.

155. Sullivan, *Study Charges Bias*, *supra* note 91; Sullivan, *New Rules Sought*, *supra* note 91.

156. *See* MINORITY ELDERLY ACCESS, *supra* note 25, at ii–iii.

157. *See* § 2000d-1.

158. *Id.*

159. Roma Stewart, Dir., Office for Civil Rights, Statement Before the U.S. Commission on Civil Rights: The Federal Responsibility for Ensuring Equal Access, *in* CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY, *supra* note 48, at 39, 48.

practicable seek the cooperation of recipients in obtaining compliance . . . and shall provide assistance and guidance to recipients to help them *comply voluntarily* . . . ."[160] Thus, HHS has tried to obtain compliance with Title VI through assurances and voluntary cooperation.[161]

Second, even if termination was an option, in a particular case, it is an overly burdensome undertaking. Termination becomes effective only after the agency submits a full written report to both the House and the Senate committees responsible for the funding.[162] Thus, it is not surprising that HHS has never terminated a nursing home for Title VI violations.[163] It is also noteworthy that no other termination process by HHS, including the termination process of nursing homes from participation in the Medicaid program because of poor quality, relies on the approval of Congress before becoming final.[164] Requiring HHS to first seek voluntary compliance and approval from Congress before termination is initiated makes Title VI little more than an ineffectual guide to what should happen, rather than a law that the nursing home administrator is required to fulfill.

The failure of Congress to provide a range of graduated remedies or sanctions other than termination for the violation of Title VI has severely restricted the regulation of health care entities under Title VI. The statutory failures to eliminate racial discrimination have translated into marginal enforcement of Title VI that has left African Americans relegated to substandard nursing homes.[165]

B. Regulatory Failures in Eradicating Racial Discrimination in Health Care

1. Civil Rights Failures by HHS

Responsible for enforcing Section 602 as applied to the health care industry, HHS is required to promulgate regulations to enforce Title VI.[166] Arguably, HHS has complied with the dictates of Title VI by promulgating regulations.[167] However, critics have noted that HHS "permitted formal assurances of compliance to substitute for verified changes in behavior, failed to collect comprehensive data or conduct affirmative compliance reviews, relied too heavily on complaints by

160. 45 C.F.R. § 80.6(a) (2009) (emphasis added).

161. *Id.*

162. *Id.* § 80.8(c).

163. *See* FEDERAL TITLE VI ENFORCEMENT, *supra* note 29, at 230–31 (noting that, as of 1996, HHS had not terminated any nursing homes for Title VI violations). For a discussion of general compliance-based terminations nationally, see Joseph Angelelli et al., *Oversight of Nursing Homes: Pruning the Tree or Just Spotting Bad Apples?*, 43 THE GERONTOLOGIST (SUPP. 2) 67, 67–75 (2003).

164. *See, e.g.*, 42 C.F.R. § 488.456(c) (regulating the termination of provider agreements).

165. *See generally* Fennell et al., *supra* note 6, at 175 (discussing racial disparities in access to long-term care).

166. 45 C.F.R. § 80.1.

167. *See* FEDERAL TITLE VI ENFORCEMENT, *supra* note 29, at 218–20 (describing the organization and duties of HHS with regard to Title VI).

victims of discrimination, inadequately investigated matters brought to the Department, and failed to sanction recipients for demonstrated violations."[168] Moreover, as noted by USCCR, there is ample evidence that HHS has consistently and systematically failed to enforce Title VI to prohibit racial discrimination in health care because of lack of funding and lax enforcement.[169]

In 1967, HHS created OCR to be the primary civil rights office for HHS to enforce Title VI.[170] Initially, most of OCR's Title VI efforts were devoted to education desegregation, while "only [four] percent of OCR's compliance efforts were devoted to health and social services . . . ."[171] In a 1980 oral and written statement to the USCCR, the Director of the OCR, Roma Stewart, highlighted the fact that the office had focused primarily on putting an end to racial discrimination in education;[172] however, with the creation of the U.S. Department of Education, she stated that OCR would focus exclusively on putting an end to racial discrimination in health care and promised to devote resources to that goal.[173] Director Stewart promised that OCR resources and staff would be dedicated to eradicating racial discrimination in health care.[174] Unfortunately, as USCCR noted in 1996, Director Stewart's promise for more resources and staff devoted to health care concerns never materialized.[175]

In 1981, OCR's staff consisted of 524 positions and the requested budget totaled $19.8 million.[176] By the 1990s, HHS' financial support and staffing of OCR decreased significantly.[177] Specifically, OCR's funding decreased beginning in 1994 and did not reach the levels spent in 1994 until 2000.[178] According to the USCCR, "[s]ince 2001, OCR's funding has continued increasing, but the increases have become smaller each year and the increases have not kept pace with inflation.[179]

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168. Lado, *supra* note 14, at 28.

169. FEDERAL TITLE VI ENFORCEMENT, *supra* note 29, at 240; HEALTH CARE CHALLENGE, *supra* note 18, at 1, 5–6, 8–9, 73–74.

170. Smith, *supra* note 18, at 86. Most divisions of HHS regulating operating programs thought of OCR as a nuisance. *Id.* at 87.

171. *Id.*

172. Stewart, *supra* note 159, at 39.

173. *Id.* at 39–41.

174. *Id.* at 40–41, 44.

175. *See* FEDERAL TITLE VI ENFORCEMENT, *supra* note 29, at 223 (stating that HHS budget and staff resources devoted to Title VI enforcement decreased).

176. *Id.* at 222 & tbl.6.1.

177. *Id.*; *see also* U.S. COMM'N ON CIVIL RIGHTS, FUNDING FEDERAL CIVIL RIGHTS ENFORCEMENT: THE PRESIDENT'S 2006 REQUEST ch. 5 & tbl.5.1 (2005), *available at* http://www.usccr.gov/pubs/crfund06/crfund06.pdf [hereinafter FUNDING FEDERAL CIVIL RIGHTS ENFORCEMENT] (determining that OCR funding decreased progressively throughout the decade when accounting for inflation).

178. FUNDING FEDERAL CIVIL RIGHTS ENFORCEMENT, *supra* note 177, at ch. 5.

179. *Id.*

The pattern of decreasing resource limitations has had a negative impact on OCR staffing levels, which has directly affected the ability of OCR to enforce Title VI. Between 1981 and 1993, OCR's staff declined from 524 to 309, while the OCR staff specifically responsible for Title VI enforcement decreased from 246 to 108.[180] From 1994 to 1999, OCR's staff decreased from 284 in 1994 to a low of 210 in 1999.[181] Consequently, "[twenty-six] percent fewer employees were available to perform its civil rights activities including complaint investigations, post-grant reviews and investigations, pre-grant reviews, monitoring and voluntary compliance reviews, and outreach."[182] In contrast, OCR's staff increased beginning in 2000, and continued to increase by ten percent each year in response to its duties under the Health Insurance Portability and Accountability Act (privacy of medical records),[183] which has nothing to do with Title VI or racial inequities.[184]

The need to increase OCR's funding and staffing was raised in 1980 by OCR Director Stewart, who planned to use OCR's "resources on systemwide compliance reviews, where patterns of discrimination can be found and corrected in ways that benefit larger numbers of people than are helped by individual case resolutions."[185] As she argued, this aspect of monitoring through systemic compliance reviews would enable OCR to "achieve more far-reaching results than can be obtained by investigation of an individual complaint" because it would produce more significant outcomes.[186] Director Stewart pledged to "have a full-fledged operation that can concentrate exclusively on an increased investigative effort, development of policy, immediate and long-range planning, and the development of a data collection program."[187]

This full-fledged operation was to address "some specific areas in which past investigations have revealed frequent problems," including "*[a]dmission practices*

180. FEDERAL TITLE VI ENFORCEMENT, *supra* note 29, at 222. The decrease in staff effected OCR's ability to enforce Title VI. OCR's internal procedures for complying with Title VI requirements called for detailed review of new nursing home applicants, yet over a twelve-year span, from 1981 to 1993, most of OCR's reviews were cursory desk-audits. *Id.* at 227 tbl.6.2. These desk-audits included a review of pre-award assurances of nondiscrimination by nursing homes, which according to the USCCR did not provide sufficient information to determine actual Title VI compliance. *Id.* at 220–21.

181. FUNDING FEDERAL CIVIL RIGHTS ENFORCEMENT, *supra* note 177, at ch. 5.

182. *Id.*

183. *Id.* The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted to improve the efficiency and effectiveness of the health care system and required HHS to adopt national standards for electronic health care transactions and code sets, unique health identifiers, and security. Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended at 42 U.S.C. § 1320d to 1320d-9 (2006 & West Supp. 2009)). HIPAA also included provisions that mandated the adoption of federal privacy protections for individually identifiable health information. *See* 42 U.S.C. § 1320d-1 (2006).

184. *See, e.g.*, 42 U.S.C. § 1320d-1 (lacking any discussion of Title VI or race).

185. Roma J. Stewart, Health Care and Civil Rights, *in* CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY, *supra* note 48, at 318, 321–22. Because of lawsuits against the government for its failure to enforce Title VI, much of its investigative staff was applied to address individual complaints. *Id.* at 322.

186. *Id.*

187. Stewart, *supra* note 159, at 39.

of hospitals and *long term care facilities* [and] . . . [t]he *failure of State Medicaid agencies to monitor* hospitals and *other providers to ensure that they do not discriminate. . . .*"[188]

OCR had also identified several problems with discrimination in nursing homes that included: "[n]ursing homes that limit Medicaid admissions to a set percentage of total numbers of patients[;] . . . [n]ursing homes that segregate minorities . . . once they have been admitted[; and f]raternally owned nursing homes that explicitly refuse to admit people of a particular race or national origin."[189] According to Director Stewart, African Americans were generally barred from nursing homes by racial discrimination, so that they were often forced to "liv[e] in unlicensed and substandard boarding homes where they cannot receive Medicaid benefits, and where the quality of care is inferior. Although most of these problems relate to accessibility, they also raise questions about the quality of care in hospitals and nursing homes."[190]

In her statement to USCCR, Director Stewart promised to take steps to address these problems by issuing regulations and providing guidance.[191] These regulations were supposed to propose new sanctions to be used against perpetrators because the agency admittedly did not like to impose termination from participation in government programs, the only remedy available to OCR.[192] Unfortunately, twenty-nine years later, Director Stewart's assurances of government enforcement of Title VI have never fully materialized. OCR never established the guidelines or implemented any new sanctions as Director Stewart promised.[193] Furthermore, OCR has been lax in its enforcement of Title VI.[194]

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188. Stewart, *supra* note 185, at 320 (emphasis added).

189. *Id.* at 324–25.

190. *Id.* at 325.

191. *See id.* at 320 (stressing the need for policy guidance). HHS issued a proposed rule on nondiscrimination requirements for block grants in 1986, but never issued a final rule. FEDERAL TITLE VI ENFORCEMENT, *supra* note 29, at 224. HHS has also failed to monitor state regulation of Title VI compliance under Medicaid. *Id.* at 232.

192. Stewart, *supra* note 159, at 49–51. In response to a question from the USCCR Commissioner Freeman regarding enforcement measures employed once discrimination is proven, Stewart said:

> Unfortunately, under the statute, the main remedy that we have is [to] cutoff of Federal funds. OCR is reluctant to cut off [sic] funds to hospitals because the very beneficiaries that we seek to assist would be further damaged. However, once a finding of discrimination is made, we undertake the attempt to achieve voluntary compliance. Most of our cases are, in fact, resolved through voluntary decisions.

Id. at 48.

193. HHS has not revised these regulations to include changes made by the Civil Rights Restoration Act of 1987, Pub. L. No. 100-259, 102 Stat. 28, and they do not address block grant programs. FEDERAL TITLE VI ENFORCEMENT, *supra* note 29, at 224. Therefore, states regulate all Title VI compliance by Medicaid certified facilities. *See id.* (noting HHS' lack of federal Title VI guidelines) HHS issued a proposed rule on nondiscrimination requirements for Medicaid in 1986, but never issued a final rule. *Id.*

194. *See, e.g., id.* at 226 (noting in the entire 1993 fiscal year, OCR only initiated twelve compliance reviews).

First and foremost, OCR has not kept up with reviewing individual complaints. A 2006 USCCR Report, noted that OCR staff levels fell between 1994 and 1999, while "OCR's pending [complaint] inventory rose exponentially, from 46 in 1994 to 1,881 in 1999 . . . . In 2000, OCR's staff increased by five, but was still not enough to handle increased post-grant review and investigation inventory."[195]

Second, in its thirty-seven year history, OCR has never terminated a nursing home proven to have violated Title VI.[196] Numerous nursing homes have been found out of compliance with Title VI, but instead of initiating legal or administrative action, OCR has only required statements of commitment to stop discrimination.[197]

Finally, OCR never instituted systematic reviews of nursing homes.[198] Instead, it has relied on private complaints and desk audits.[199] Nevertheless, according to the U.S. House of Representatives, OCR failed to even complete this task.[200]

As early as 1987, the U.S. House of Representatives Committee on Government Operations determined "that OCR unnecessarily delayed case processing, allowed discrimination to continue without federal intervention, routinely conducted superficial and inadequate investigations, failed to advise regional offices on policy and procedure for resolving cases, and abdicated its responsibility to ensure that HHS policies are consistent with civil rights law, among other things."[201] The same committee "criticized OCR's reluctance to sanction noncompliant recipients and recommended that OCR pursue investigations of complaints as well as compliance reviews in more systematic ways."[202] Since this report, not much has changed.

Fifteen years later, there was little progress to report. In its 2002 report, USCCR noted that OCR's civil rights system was rudimentary.[203] Although

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195. FUNDING FEDERAL CIVIL RIGHTS ENFORCEMENT, *supra* note 177, at ch. 5.

196. *See supra* note 163 and accompanying text.

197. *See, e.g.*, FEDERAL TITLE VI ENFORCEMENT, *supra* note 29, at 230–31 ("Of the [twenty-one] Title VI compliance reviews completed in 1993, [ten] resulted in findings of noncompliance. Each of these . . . was . . . resolved through corrective action commitments . . . .").

198. *See id.* at 220 (determining that HHS does not actively engage in Title VI enforcement).

199. *See id.* at 220–21 (stating that operating divisions conduct desk audits as opposed to post-award reviews).

200. Lado, *supra* note 14, at 29–30 (citing H. COMM. ON GOV'T OPERATIONS, INVESTIGATION OF THE OFFICE FOR CIVIL RIGHTS IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, H.R. REP. NO. 100-56, at 14, 22–25 (1987)).

201. *Id.* at 29.

202. *Id.* at 29–30.

203. U.S. COMM'N ON CIVIL RIGHTS, TEN-YEAR CHECK-UP: HAVE FEDERAL AGENCIES RESPONDED TO CIVIL RIGHTS RECOMMENDATIONS? VOLUME I: A BLUEPRINT FOR CIVIL RIGHTS ENFORCEMENT 5–6 (2002), *available at* http://www.law.umaryland.edu/marshall/usccr/documents/tenyrchekupvol1.pdf [hereinafter TEN-YEAR CHECK-UP].

USCCR noted that HHS had established civil rights enforcement programs, USCCR found that these programs were unsatisfactory.[204] USCCR "found [OCR's] efforts to develop policy and conduct civil rights enforcement activities to be halfhearted."[205] Although Title VI provided the legal framework to eliminate racial discrimination in health care, USCCR stated without equivocation that "HHS lacks a vigorous civil rights enforcement program, and the activities of OCR appear to have little impact on the agency as a whole."[206]

The federal government's failure to enforce Title VI, which prohibits government-funded racial discrimination, has led to the perpetuation of racially discriminatory practices in the long-term care system. By failing to punish nursing homes that violate Title VI, the federal government has implicitly accepted the practice of racial discrimination. The federal government's failures have been exacerbated by state actions of setting low reimbursement rates for Medicaid certified nursing homes[207] and the delegation of admissions decisions to the perpetrators of racial discrimination.[208]

2. Civil Rights Failures by the States

The limited record of states' enforcement of Title VI has not been much better than HHS. Because the states administer the Medicaid program, the states are required to determine Title VI compliance of nursing homes and report their findings to OCR.[209] To fulfill this mandate, states are required to review private complaints and conduct annual reviews of compliance documents.[210] There is limited information regarding the states' efforts to fulfill this mandate; however, the available information, which includes empirical data,[211] government reports,[212]

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204. *Id.* at 5.

205. *Id.*

206. HEALTH CARE CHALLENGE, *supra* note 18, at 74.

207. *See, e.g.*, Thomas Day, About Nursing Homes, http://www.longtermcarelink.net/eldercare/nursing_home.htm (last visited June 14, 2010) (stating that Medicaid reimbursement rates are not uniform from state to state, and that some nursing home associations claim that eighty-five percent of their members are not meeting costs with Medicaid).

208. *See, e.g.*, Smith, *supra* note 6, at 863 (explaining how nursing homes have much discretion in admissions).

209. *See* FEDERAL TITLE VI ENFORCEMENT, *supra* note 29, at 224 (indicating that HHS has not published any Title VI guidelines for its programs). According to the USCCR, "HHS has not implemented a systematic process to review [s]tates' Title VI compliance activities on a regular basis" under Medicaid. *Id.* at 232. Furthermore, the states' Title VI compliance websites are not linked to OCR. *E.g.*, Div. of Minority Health & Disparity Elimination, Tenn. Dep't of Health, Office of Title VI, http://health.state.tn.us/dmhde/title6.shtml (last visited June 14, 2010); Office of Citizen Servs., N.C. Dep't of Health & Human Servs., The Title VI of the Civil Rights Act of 1964 Limited English Proficiency (LEP), http://www.dhhs.state.nc.us/ocs/title6.htm (last visited June 14, 2010).

210. *See* FEDERAL TITLE VI ENFORCEMENT, *supra* note 29, at 232 (describing state compliance requirements with Title VI).

211. *See* Falcone & Broyles, *supra* note 6, at 588–92 (comparing delayed discharge days and race with controls for other predictors of delay); Smith, *supra* note 6, at 862–66 (analyzing reimbursement

and case law,[213] shows that the states' efforts in fulfilling their duties under Title VI have been ineffectual.

States do not have agencies comparable to OCR that are responsible for Title VI compliance in health care. For example, in Tennessee, the Division of Minority Health and Disparity Elimination, of the Tennessee Department of Health, enforces Title VI and submits a yearly Title VI Compliance Plan and Implementation Manual to the State Comptroller's Office.[214] However, in North Carolina, there is one Title VI compliance attorney in the Office of General Counsel, a division of the North Carolina Department of Health and Human Services.[215] In Illinois, there is no one responsible for reviewing Title VI compliance in health care.[216] Therefore, it is impossible to determine who is responsible in the states for Title VI enforcement in health care.

Furthermore, it is difficult to ascertain the effectiveness of the states' Title VI compliance efforts from government reports. If any reports are issued, they are sporadic. For instance, the New York Advisory Committee issued the first report regarding issues of racial inequities in health care in 1964.[217] Twenty-eight years later, the New York Advisory Committee issued a report regarding racial inequities cause by racial discrimination in the admission practices of nursing homes.[218] As a result of the report, New York required nursing homes that kept a waiting list for

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rates and fixed-price payment methods); Weissert & Cready, *supra* note 6, at 632–42 (reviewing the number of days a patient was delayed before being granted admission, and discussing factors contributing thereto).

212. *E.g.*, MINORITY ELDERLY ACCESS, *supra* note 25, at 15; TEN-YEAR CHECK-UP, *supra* note 203, at 5–6, 26–27 & n.143. *See also* Sullivan, *Study Charges Bias*, *supra* note 91 (describing the release of civil rights documents required by the State Health Department on nursing homes); Sullivan, *New Rules Sought*, *supra* note 91 (discussing the allegations of a New York State task force studying racial segregation in nursing homes).

213. *See, e.g.*, Taylor v. White, 132 F.R.D. 636, 640 (E.D. Pa. 1990) (finding that Medicaid recipients had standing to bring action against state officials for discrimintaory practices in Medicaid-based nursing home admissions); Linton *ex rel.* Arnold v. Comm'r of Health & Env't, 779 F. Supp. 925, 935–36 (M.D. Tenn. 1990) (ruling that Tennessee's bed certification policies fostered racial discrimination and ordered the state to change its policies).

214. Div. of Minority Health & Disparity Elimination, Tenn. Dep't of Health, *supra* note 209.

215. Office of Citizen Servs., N.C. Dep't of Health & Human Servs., *supra* note 209.

216. Conversation with staff of the Illinois Dep't of Public Health, Bureau of Long-Term Care (Sept. 10, 2009). In response to my testimony before the Public Health Committee of the Illinois Senate, I was contacted by an attorney at the Illinois Department of Public Health. *See The Persistence of Racial Inequities in Nursing Home Care: Hearing Before the S. Comm. on Public Health*, 96th Gen. Assem. (Ill. 2009) (statement of Ruqaiijah Yearby) (on file with author). The attorney told me that although there is no written policy, complaints of racial discrimination are forward to either OCR or the Illinois Human Rights Department. Conversation with staff of the Illinois Dep't of Public Health, Bureau of Long-Term Care (Feb. 2, 2010).

217. *See generally* MINORITY ELDERLY ACCESS, *supra* note 25, at ii (referencing the 1964 report).

218. *See id.* (noting how the Committee's 1992 report discussed the level of access that minorities have to health services, and examined how New York State nursing homes treat minorities, including in the area of admissions).

admissions to make the lists public.[219] However, this did not change the practices of most nursing homes because they did not keep waiting lists for admission.

According to David Barton Smith, as long as nursing homes made a "good faith" effort by marketing with nondiscriminatory language and submitting written assurances of nondiscrimination, the states certified nursing homes to participate in Medicaid without meaningful investigation of the veracity of these assurances.[220] After certifying the nursing homes, states gave these nursing homes full discretion in admission decisions.[221] Some nursing homes have used this discretion to implement policies that deny admission to 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.[222] In New York, studies show that some quality nursing homes deny admission to African Americans relegating them to substandard nursing homes.[223] Furthermore, in Ohio a nursing home was alleged to deny admission to African Americans because of their race.[224] Unchecked by the states, these practices have become standard and reinforce a separate and unequal system.[225] Lawsuits have challenged these discriminatory admission practices;[226] however, there have been no systemic changes in state regulation of nursing home admission policies, except in Tennessee.[227]

Tennessee has implemented a regulatory framework that tracks and addresses discriminatory admission practices by nursing homes. In response to a lawsuit,[228] the state requires all nursing homes receiving Medicaid payments to submit admission data.[229] This data is checked against mandated admission lists and the medical records of admitted patients to ensure that the nursing home is not discriminating.[230] Unfortunately, Tennessee's policies are not standard across the

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219. Conversation with Margaret Flint, Prof. of Law, Pace Law Sch.; Pres. of Friends & Relatives of Institutionalized Aged (a nursing home advocacy organization); Member of the Board of Directors, Westchester Residential Opportunities (Sept. 2, 2009).

220. SMITH, *supra* note 12, at 236.

221. *See supra* note 208 and accompanying text.

222. *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).

223. MINORITY ELDERLY ACCESS, *supra* note 25, at ii–iii; Sullivan, *Study Charges Bias*, *supra* note 91; Sullivan, *New Rules Sought*, *supra* note 91.

224. Brief of Plaintiff, *supra* note 5, at 4–6.

225. *See* cases cited *supra* note 5.

226. *E.g.*, Taylor v. White, 132 F.R.D. 636, 639 (E.D. Pa. 1990); Linton *ex rel.* Arnold v. Comm'r of Health & Env't, 779 F. Supp. 925, 927 (M.D. Tenn. 1990).

227. *See infra* notes 228–30 and accompanying text.

228. *See Linton*, 779 F. Supp. at 926, 936 (ordering the State of Tennessee to submit a plan to redress the disparate impact its bed certification policy had on minority Medicaid patients).

229. TENN. COMP. R. & REGS. 1200-13-01-.08 (2009).

230. *Id.*

nation. In Illinois, there is no mention of Title VI or a prohibition against racial discrimination in the laws governing long-term care facilities, such as nursing homes.[231] Therefore, Illinois does not regulate nursing homes Title VI compliance. In New York, the regulations prohibit nursing homes from denying admission based on race.[232] However, the law fails to provide enforcement procedures.

Overall the failures of Title VI are linked to statutory and regulatory failures to eliminate racial discrimination in health care. The USCCR has stated that "[i]f OCR continues to focus its enforcement on the more tangible civil rights violations, without delving into the reasons they exist in the first place, it will fail to recognize and eliminate the true sources of inequity."[233] Consistent with this perspective, the USCCR recommended a reorganization of the entire civil rights structure to prohibit racial discrimination in health care. Specifically, the USCCR suggested that "OCR . . . conduct broad-based, systemic compliance reviews on a rotating basis in *all* federally funded health care facilities, at least every [three] years."[234] These recommendations would improve the entire health care delivery system. However, because of the historical racial inequities in this industry, additional changes, which are discussed below, need to be made in the nursing home enforcement system if discrimination is to be ended.

III. PUTTING AN END TO RACIAL DISCRIMINATION THROUGH CHANGES TO THE NURSING HOME ENFORCEMENT SYSTEM

To put an end to racial discrimination in nursing homes, civil rights enforcement must be integrated into every facet of regulation of nursing homes. While the government has improved the quality of care provided to nursing home residents under the nursing home enforcement system, the Title VI enforcement system has been ignored. The time has come for both systems to be integrated to ensure access to quality health care for all nursing home residents.

Integrating these systems would provide significant benefits. The burden of investigating racial inequities would fall on those actually regulating the nursing home enforcement system instead of the under-funded and under-staffed civil rights offices of HHS and the states. The administrative burden on those regulating the nursing home enforcement system would be minimal because they already collect racial data.[235] Moreover, integration would allow for the imposition of sanctions that are used in the nursing home enforcement system, such as fines,

231. *See* 210 ILL. COMP. STAT. ANN. 45/1-101 to -131 (West 2000) (omitting any reference to Title VI or racial discrimination from the state's Nursing Home Care Act).

232. N.Y. COMP. CODES R. & REGS. tit. 10, § 415.26(i)(1)(ix) (2009).

233. HEALTH CARE CHALLENGE, *supra* note 18, at 203.

234. *Id.*

235. *See* Smith et al., *supra* note 63, at 867–68 (analyzing state data, and noting that states "promulgate and enforce regulations related to nursing homes including those related to civil-rights laws").

rather than termination of Medicaid provider agreement, which HHS rarely imposes in any situation.

Although Title VI compliance is mentioned in the regulations governing the nursing home enforcement system,[236] the systems remain separate. For instance, Title VI enforcement and nursing home enforcement systems are enforced by different federal[237] and state entities,[238] with no collaboration. The overwhelming evidence points to the policy conclusion that to be meaningful, the integration of civil rights enforcement must go beyond these textual references at every level of government. It must include sharing resources, personnel, and remedies.

A. History of Nursing Home and Title VI Enforcement Systems

When Congress enacted the Medicaid Act, it tried to induce nursing homes to comply with the nondiscriminatory requirements of Title VI and regulate the

236. 42 C.F.R. § 442.12(d)(2) (2009); 45 C.F.R. § 80.3 (2009).

237. On the federal level, the Office of Civil Rights (OCR), a division of HHS, enforces Title VI, while the Centers for Medicare and Medicaid Services (CMS), also a division of HHS, enforces the nursing home regulations. *See, e.g.*, OFFICE OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. NO. OEI-06-03-00410, NURSING HOME ENFORCEMENT: APPLICATION OF MANDATORY REMEDIES 1–10 (2006) (discussing CMS enforcement of nursing home regulations); Office of Civil Rights, U.S. Dep't of Health & Human Servs., OCR Nondiscrimination Laws, Regulations, and Standards, http://www.hhs.gov/ocr/civilrights/resources/laws/index.html (last visited June 14, 2010) (discussing OCR enforcement of nondiscrimination laws). When you visit state websites regarding nursing home enforcement, they have a link to CMS's Nursing Home Compare website. *E.g.*, Tenn. Dep't of Health, Nursing Home Information, http://health.state.tn.us/nursinghomes/ (last visited June 14, 2010); N.C. Div. of Aging & Adult Servs., Nursing Homes, http://www.dhhs.state.nc.us/aging/nhome.htm (last visited June 14, 2010). However, even though the states are responsible for Title VI compliance, OCR's websites does not provide links to state websites. Office of Civil Rights, U.S. Dep't of Health & Human Servs., How to File a Civil Rights Complaint, http://www.hhs.gov/ocr/civilrights/complaints/index.html (last visited June 14, 2010). Instead OCR requests all complaints be submitted to regional OCR offices. *Id.*

238. The regulation of Title VI and nursing homes is done differently in each state; however, the enforcement remains separate. For example, in Tennessee, the Division of Minority Health and Disparity Elimination enforces Title VI, while the Division of Health Care Facilities regulates nursing home enforcement system. Div. of Minority Health & Disparity Elimination, Tenn. Dep't of Health, *supra* note 209; Tenn. Dep't of Health, *supra* note 237. Although both divisions are a part of the Tennessee Department of Health, the Division of Minority Health and Disparity Elimination submits a Title VI Compliance Plan and Implementation Manual to the State Comptroller's Office yearly, while the Division of Health Care Facilities works with the State and CMS. In North Carolina, there is a Title VI compliance attorney in the Office of General Counsel, while the Division of Aging and Adult Services regulates the nursing home enforcement system. Office of Citizen Servs., N.C. Dep't of Health & Human Servs., *supra* note 209; N.C. Div. of Aging & Adult Servs., *supra* note 237. The Title VI compliance attorney and the Division of Aging and Adult Services are a part of the North Carolina Department of Health and Human Services. However, one person handles Title VI compliance for all health care entities, whereas an entire division is in charge of nursing home enforcement. Office of Citizen Servs., N.C. Dep't of Health & Human Servs., *supra* note 209.

quality of health care provided by nursing homes.[239] Both the broader Title VI enforcement system and the nursing home enforcement system were implemented in 1965.[240] Both enforcement systems started on shaky ground; yet the nursing home enforcement system has been effective in providing meaningful improvements in the provision of quality nursing home care, whereas the civil rights system has not.

Congress tried to use Medicaid funding to ensure compliance with Title VI,[241] which was instrumental in putting an end to racial discrimination in hospitals across the country.[242] Nursing homes, however, were not interested in government funding, nor was the government dedicated to enforcing Title VI. As Professor David Barton Smith notes, when Title VI was enacted "President Johnson apparently had decided not to enforce compliance in nursing homes, to rely on paper assurances alone."[243] Hence, nursing homes were allowed to continue their discriminatory practices.[244]

During the 1960s and 1970s, the low reimbursement rates of Medicaid led many nursing homes to forgo participation in the programs.[245] Instead, nursing homes sought private pay patients.[246] By the time nursing homes began participating in these programs in the 1980s, the issue of Title VI enforcement was no longer a focal point for the government.[247] Instead, the government's main

239. *See* 42 C.F.R. § 442.12(d)(2) (requiring a facility to comply with civil rights requirements); SMITH, *supra* note 12, at 159–61 (discussing federal efforts to ensure compliance with Title VI). The Medicare Act was also used to induce compliance with Title VI. SMITH, *supra* note 12, at 159–61.

240. SMITH, *supra* note 12, at 108–10 (Title VI enforcement system); Virender Kumar et al., *OBRA 1987 and the Quality of Nursing Home Care*, 6 INT'L J. HEALTH CARE FIN. & ECON. 49, 51 (2006) (nursing home enforcement system).

241. *See* Civil Rights Act of 1964, 42 U.S.C. § 2000d-1 (2006) (directing federal agencies funding programs or activities "to effectuate the provisions of [the Civil Rights Act] with respect to such program or activity by issuing rules, regulations, or orders of general applicability which shall be consistent with achievement of the objectives of the statute authorizing the financial assistance in connection with which the action is taken").

242. *See* SMITH, *supra* note 12, at 137 (discussing successful efforts to secure Title VI compliance). Faced with the loss of a substantial source of revenue stream, most hospitals integrated overnight. *See id.* (describing the hasty merge of a Caucasian hospital with an African American hospital in North Carolina to receive Medicare funding, and the overnight integration of blood supply to keep federal funds).

243. *Id.* at 160.

244. *Id.* at 159–61.

245. David Barton Smith, *Population Ecology and the Racial Integration of Hospitals and Nursing Homes in the United States*, 68 MILBANK Q. 561, 576 (1990).

246. *See* SMITH, *supra* note 12, at 161 (describing nursing homes' preference for out-of-pocket payments to avoid participation in Medicare or Medicaid).

247. *Id.* at 249 ("[C]oncerns about nursing-home minority access and discrimination were relegated to periodic reports that collected dust."). *See* Ruqaiijah Yearby, *Is It Too Late for Title VI Enforcement?—Seeking Redemption of the Unequal United States' Long Term Care System Through International Means*, 9 DEPAUL J. HEALTH CARE L. 971, 993–94 (2005) (noting a 1987 report from the United States House of Representatives Committee on Government Operations, which discovered that

priority was to initiate cutbacks in response to rising health care costs.[248] The government initiated cutbacks in the face of evidence that to achieve racial integration of health care entities, such as nursing homes, the states needed to increase reimbursement rates for Medicaid.[249]

Initially, the nursing home enforcement system did not fare much better. The nursing home enforcement standards were so severe that only about twelve percent of the 6,000 nursing homes that applied to participate in Medicaid were certified.[250] Another fifty percent were designated as being in "substantial compliance" and allowed to participate in the Medicaid program.[251] In response to these developments, Congress amended the Medicaid program in 1967, creating less rigorous enforcement standards for participation.[252]

Since 1967, the nursing home enforcement system has been overhauled several times. In 1974, the nursing home enforcement standards[253] were changed to allow a facility in violation of the regulations an opportunity to correct before the imposition of termination.[254] To resolve nursing home violations, states were mandated to send a notice of the violations to the facility and give the facility a thirty- to sixty-day grace period to correct violations.[255] If the facility failed to become compliant by the end of that time period, then and only then could the state impose the sanction of terminating the Medicaid provider agreement.[256]

OCR "allowed discrimination to continue without federal intervention . . . and abdicated its responsibility to ensure that HHS policies are consistent with civil rights law, among other things").

248. Smith, *supra* note 245, at 576–77.

249. *See id.* at 577 (indicating that achieving greater access to health care for African American Medicaid patients would increase the costs of the program, straining participating health care entities).

250. INST. OF MED., IMPROVING THE QUALITY OF CARE IN NURSING HOMES 241 (1986).

251. *Id.*

252. *Id.* at 242; *see also* Social Security Amendments of 1967, Pub. L. No. 90-248, 81 Stat. 821 (regulating intermediate care facilities); Institutional Services in Intermediate Care Facilities, 34 Fed. Reg. 9782, 9782–84 (June 24, 1969) (codified as amended at 45 C.F.R. § 234.130 (2009)) (implementing intermediate care facilities); Assistance in Form of Institutional Services in Intermediate Care Facilities, 33 Fed. Reg. 12,925, 12,925–26 (Sept. 12, 1968) (presenting interim policies and requirements for intermediate care facilities).

253. Skilled Nursing Facilities, 39 Fed. Reg. 2238, 2238–54 (Jan. 17, 1974). Under these regulations, HHS created an office in the federal regional offices to regulate and oversee state enforcement efforts of all long-term care facilities. INST. OF MED., *supra* note 250, at 245. Nevertheless, many states chose not to implement or enforce these regulations. *See id.* at 245–46 (explaining that state compliance varied widely among states even after the 1974 regulations).

254. U.S. GEN. ACCOUNTING OFFICE, PUB. NO. GAO/HRD-87-113, MEDICARE AND MEDICAID: STRONGER ENFORCEMENT OF NURSING HOME REQUIREMENTS NEEDED 23, 27–28 (1987).

255. INST. OF MED., *supra* note 250, at 148; *see also* Skilled Nursing Facilities, 39 Fed. Reg. at 2253 (requiring "a reasonable time to achieve compliance," and defining *reasonable* as within sixty days).

256. INST. OF MED., *supra* note 250, at 148; *see also* U.S. GEN. ACCOUNTING OFFICE, *supra* note 254, at 10.

In 1980, Congress created an intermediate sanction, denial of payments for new Medicaid admissions, for use in the nursing home enforcement system.[257] Nevertheless, a nursing home found out of compliance with the Medicaid regulations was still given the opportunity to develop and implement a plan of correction for its deficiencies before the imposition of the intermediate sanction.[258] If the facility was unable to fulfill the requirements set forth in the plan of correction, the Secretary then had the right to impose the sanction of denial of payments for new admissions.[259] Prior to this change, termination was the only remedy available to rectify violations of either the Title VI or the nursing home enforcement systems.

Congress created this new process and sanction because HHS and the states rarely imposed termination. It was anticipated that the intermediate sanction would "serve to protect beneficiaries both by giving the skilled nursing facility an incentive to correct deficiencies in a timely manner" without forcing HHS or the states to shut down the nursing home.[260] When the intermediate sanction was added to the nursing home enforcement system, there was no mention of the need to add an intermediate sanction to the Title VI enforcement system. Consequently, because HHS rarely imposes termination in any instance, the failure to add an intermediate sanction for Title VI violations left those violating Title VI without an incentive to comply with Title VI.

In 1987, Congress passed the NHRA, dramatically changing the standards and sanctions used in the nursing home enforcement system.[261] Congress enacted a set of standards that authorized HHS to aggressively police nursing homes through the imposition of new sanctions (now called remedies), including denial of payment for new admissions, civil money penalties, and temporary management.[262] Under the new nursing home enforcement system, nursing homes were no longer provided an opportunity to voluntarily comply with the requirements before the imposition of remedies.[263]

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257. Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 916, 94 Stat. 2599, 2623–25. These remedies were imposed for violations that did not cause serious harm. *Id.*

258. H.R. REP. NO. 96-1167, at 56 (1980), *as reprinted in* 1980 U.S.C.C.A.N. 5526, 5569.

259. *Id.*

260. *Id.* at 57. Congress recognized that states already had a full array of sanctions for Medicaid and said that this rule would not pre-empt these sanctions. *Id.*

261. *See* discussion *supra* note 43.

262. H.R. REP. NO. 100-391(I), at 475–77 (1987), *as reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-295 to -297. "Temporary management means the temporary appointment by [HHS] or the State of a substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility's operation." 42 C.F.R. § 488.415 (2009).

263. CTRS. FOR MEDICARE & MEDICAID SERVS., STATE OPERATIONS MANUAL: CHAPTER 7—SURVEY AND ENFORCEMENT PROCESS FOR SKILLED NURSING FACILITIES AND NURSING FACILITIES §§ 7304, 7304C (2004), *available at* http://www.cms.hhs.gov/manuals/downloads/som107c07.pdf [hereinafter CTRS. FOR MEDICARE & MEDICAID SERVS., SOM CH. 7].

Incorporated into the Medicaid Act, the NHRA improved the quality of health care provided in nursing homes. Although there is still work to be done, the current nursing home enforcement system has improved the quality of care provided to most residents. However, African Americans continue to disproportionately receive poor quality care compared to Caucasians, due to governmental failures to enforce Title VI.[264]

B. Current Nursing Home Enforcement System

Under the current nursing home enforcement system, HHS has delegated its authority to the states and the Centers for Medicare and Medicaid Services (CMS),[265] a division of HHS.[266] The states administer the program by certifying nursing homes to participate in Medicaid and reviewing their annual compliance with the Medicaid Act.[267] CMS then reviews the state's findings for accuracy; however, it often defers to the state's findings.[268]

For example, to participate in Medicaid, a nursing home must enter into a provider agreement with the state.[269] The state must conduct an initial survey and certify the facility's compliance with the Medicaid conditions of participation for nursing homes[270] and with the civil rights regulations[271] before an agreement is finalized.[272] If a nursing home fulfills these requirements, the state will enter into a Medicaid provider agreement with the nursing home.

After entering into a Medicaid provider agreement with the state, state surveyors determine a nursing home's compliance with the Medicaid conditions of participation[273] through the compliance review process called "survey and

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264. *See supra* Part I.

265. In 1977, CMS, formerly known as the Health Care Financing Administration (HCFA), was created to administer and regulate Medicaid. *See* Department of Health, Education, and Welfare, Reorganization Order, 42 Fed. Reg. 13,262, 13,262 (Mar. 9, 1977) (establishing and authorizing the HCFA to administer Medicaid and Medicare); Centers for Medicare & Medicaid Services; Statement of Organization, Functions and Delegations of Authority; Reorganization Order, 66 Fed. Reg. 35,437, 35,437 (July 5, 2001) (renaming the HCFA as CMS). To prevent any confusion, this Article solely refers to the agency as CMS.

266. Centers for Medicare & Medicaid Services; Statement of Organization, Functions and Delegations of Authority; Reorganization Order, 66 Fed. Reg. at 35,437.

267. CTRS. FOR MEDICARE & MEDICAID SERVS., STATE OPERATIONS MANUAL: CHAPTER 1—PROGRAM BACKGROUND AND RESPONSIBILITIES §§ 1002, 1004 (2004), *available at* http://www.cms.hhs.gov/manuals/downloads/som107c01.pdf [hereinafter CTRS. FOR MEDICARE & MEDICAID SERVS., SOM CH. 1]. 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. *Id.* § 1008B. Usually, CMS determinations are based on State survey findings. *Id.* § 1006.

268. CTRS. FOR MEDICARE & MEDICAID SERVS., SOM CH. 7, *supra* note 263, §§ 7807A, 7807B.

269. 42 C.F.R. § 442.12(a) (2009).

270. *Id.*

271. *Id.* § 442.12(d)(2).

272. *Id.*

273. *Id.* § 488.300.

certification."[274] 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.[275] Nursing homes certified to participate in Medicaid are required to fulfill the conditions of participation for all residents, regardless of the payment status of the resident.[276]

State surveyors use fifteen conditions of participation to review the compliance of nursing homes with the Medicaid Act.[277] These conditions include: resident rights,[278] resident behavior,[279] quality of life,[280] resident assessment,[281] quality of care,[282] nursing services,[283] dietary services,[284] physician services,[285] rehabilitative services,[286] dental services,[287] pharmacy services,[288] infection control,[289] administration,[290] admission and transfer rights,[291] and physical environment.[292] Under the current survey and certification process, once a nursing home is certified to participate in Medicaid, the home is visited every nine to fifteen months[293] by a state health agency survey team[294] often comprised of nurses,

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274. 42 U.S.C. § 1396r(g)(1) (2006 & West Supp. 2009); 42 C.F.R. §§ 488.300–.335 (Subpart E—Survey & Certification of Long-Term Care Facilities). HHS requires that the states develop a survey plan to that complies with the requirements of 42 C.F.R. subpts. E–F. 42 C.F.R. § 488.303(a). Under this plan, the states may establish a program to reward, through public recognition or incentive payments (or both) nursing homes that provide the highest quality of care to Medicaid residents. *Id.* § 488.303(b).

275. Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., Conditions for Coverage (CfCs) & Conditions of Participations (CoPs): Overview, http://www.cms.gov/CFCsAndCoPs/ (last visited June 14, 2010).

276. 42 U.S.C. § 1396r(b)(4)(A) (making no distinction between the payment statuses of individual residents).

277. 42 C.F.R. §§ 483.1(b), .10–.75. 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. CTRS. FOR MEDICARE & MEDICAID SERVS., SOM CH. 1, *supra* note 267, §§ 1000, 1000B, 1002.

278. 42 C.F.R. § 483.10.

279. *Id.* § 483.13.

280. *Id.* § 483.15.

281. *Id.* § 483.20.

282. *Id.* § 483.25.

283. *Id.* § 483.30.

284. *Id.* § 483.35.

285. *Id.* § 483.40.

286. *Id.* § 483.45.

287. *Id.* § 483.55.

288. *Id.* § 483.60.

289. *Id.* § 483.65.

290. *Id.* § 483.75.

291. *Id.* § 483.12.

292. *Id.* § 483.70.

293. *See id.* § 488.308 (requiring an average interval of twelve months between surveys and no later than fifteen months after the previous survey). This survey is called an annual standard survey. A

nutritionists, social workers, and physical therapists.[295] The survey team assesses whether the nursing home continues to be in compliance with the Medicaid conditions of participation, which are a compilation of federal and state laws.[296]

The survey and certification process is different in each state, but generally includes several steps.[297] Before entering the facility, the survey team reviews numerous documents, including but not limited to the resident assessment instrument (RAI),[298] the facility quality measures and indicators,[299] and the facility's historical compliance data.[300] The team uses these documents to determine the facility's past and current compliance with the Medicaid conditions of participation.[301] After reviewing the data, the survey team conducts an entrance conference with the nursing home administrator. The team then conducts an initial tour of the facility to: "[p]rovide an initial review of the facility, the residents, and the staff; [o]btain an initial evaluation of the environment of the facility, including the facility kitchen; and [c]onfirm or invalidate the pre-selected concerns, if any, and add concerns discovered onsite."[302] After the initial tour, the surveyors select at random a group of residents for an in-depth review of their care as provided by the nursing home.[303] The review includes medical record reviews, observations of

standard survey is "a periodic, resident-centered inspection [that] gathers information about the quality of service furnished in a facility to determine compliance with the requirements for participation." *Id.* § 488.301. There are three other types of surveys: abbreviated, validation, and extended standard survey. *Id.* An abbreviated standard survey is "a survey other than a standard survey that gathers information primarily through resident-centered techniques on facility compliance with the requirements for participation." *Id.* An extended standard survey is "a survey that evaluates additional participation requirements subsequent to finding substandard quality of care during a standard survey." *Id.* A validation survey is "a survey conducted by the Secretary [of HHS] within [two] months following a standard survey, abbreviated standard survey, partial extended survey, or extended survey for the purpose of monitoring State survey agency performance." *Id.* Although named differently, the compliance requirements are the same.

294. *Id.* § 488.305.

295. *Id.* § 488.314.

296. *See id.* § 482.23 (stating that nursing services' conditions of participation are a compilation of federal and state laws); CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., STATE OPERATIONS MANUAL: APPENDIX P—SURVEY PROTOCOL FOR LONG-TERM CARE FACILITIES PART I, at pt. I (2009), *available at* http://cms.hhs.gov/manuals/Downloads/som107ap_p_ltcf.pdf [hereinafter CTRS. FOR MEDICARE & MEDICAID SERVS., SOM APP. P] (explaining that the survey relies on sampling of residents to gather information about the facility's compliance with participation requirements).

297. CTRS. FOR MEDICARE & MEDICAID SERVS., SOM APP. P, *supra* note 296, pt. I (showing there are several steps in the survey and certification process, and describing those steps).

298. 42 C.F.R. § 483.20(b). The resident assessment instrument (RAI) is coded and transmitted to the minimum data set (MDS). *Id.* § 483.20(f).

299. The facility quality measures and indicators are based on information from the data from the MDS. CTRS. FOR MEDICARE & MEDICAID SERVS., SOM APP. P, *supra* note 296, pt. II.B.1.

300. *Id.*

301. *Id.*

302. *Id.*

303. *Id.*

direct resident care, resident interviews, family interviews, and observations of events such as activities and meals.[304] The surveyor team members then meet to discuss their findings and determine the nursing homes compliance with the Medicaid conditions of participation.[305]

For the final step in the survey process, the survey team meets with the administrative staff and shares its preliminary findings. If the survey team finds the nursing home out of compliance with the Medicaid conditions of participation, it cites the facility for a deficiency and shares this information with the administrative staff.[306] After the meeting, the survey team drafts a Statement of Deficiencies (SOD) detailing the nursing home's noncompliance and factual incidents to support these allegations.[307] The state's findings of noncompliance are final, except in the case of a state-operated, Medicaid-only nursing home.[308]

In the SOD, each deficiency is assigned a scope and severity level based on the egregiousness of the offense.[309] The scope is the number of residents affected and the severity level refers to the seriousness of the harm.[310] The scope and severity of each deficiency assigned is based on the matrix shown below in Table 1.

304. *Id.* pt. II.A.1.

305. *Id.* pt. II.B.1.

306. OFFICE OF INSPECTOR GEN., *supra* note 113, at 1. There are a total of 190 possible deficiencies based on the fifteen conditions of participation, for which the states can cite a nursing home. *Id.* Most deficiencies are categorized into three main areas: quality of care, 42 C.F.R. § 483.25 (2009), quality of life, *id.* § 483.15, and resident behavior and facility practice, *id.* § 483.13.

307. *See* 42 C.F.R. § 488.402(f)(1) (describing the notification requirements for the facility). The state submits its findings on the HHS Online Survey Certification and Reporting system for HHS approval. *Id.* §§ 488.330(d), .402(f)(1); *see also* OFFICE OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. NO. OEI-02-98-00330, NURSING HOME SURVEY AND CERTIFICATION: OVERALL CAPACITY 10 (1999), *available at* http://oig.hhs.gov/oei/reports/oei-02-98-00330.pdf (noting that the Online Survey Certification and Reporting (OSCAR) database is where all state survey information is stored). 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. §§ 488.18(b)(1), .402(f)(2)(ii). Even after HHS approves the SOD, nursing homes can appeal any deficiencies or remedies through an informal dispute resolution process. *Id.* § 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 THE GERONTOLOGIST 772, 773 (2006).

308. CTRS. FOR MEDICARE & MEDICAID SERVS., SOM CH. 1, *supra* note 267, § 1016.

309. *See* 42 C.F.R. § 488.404 (requiring the seriousness to be described in levels of "[a]ctual harm" and the scope to be described in terms of whether the deficiencies "(i) [a]re isolated; (ii) [c]onstitute a pattern; or (iii) [a]re widespread").

310. *Id.* § 488.404(b).

TABLE 1: SCOPE AND SEVERITY OF MEDICAID DEFICIENCIES[311]

Severity	Scope		
	Isolated[312]	Pattern[313]	Widespread[314]
Immediate jeopardy to resident health/safety[315]	J	K	L
Actual harm that is not immediate jeopardy[316]	G	H	I
No actual harm with potential for more than minimal harm that is not immediate jeopardy[317]	D	E	F
No actual harm with a potential for minimal harm[318]	A	B	C

311. Letter from Daniel R. Levinson, Inspector Gen., U.S. Dep't of Health & Human Servs., to Kerry Weems, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs. (Sept. 18, 2008), at 3 fig.1, *available at* http://oig.hhs.gov/oei/reports/oei-02-08-00140.pdf.

312. "Scope is isolated when one or a very limited number of residents are affected and/or one or a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations." CTRS. FOR MEDICARE & MEDICAID SERVS., SOM APP. P, *supra* note 296, pt. IV.C.

313.

> Scope is a pattern when more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice. The effect of the deficient practice is not found to be pervasive throughout the facility.

Id. pt. IV.C.

314.

> Scope is widespread when the problems causing the deficiencies are pervasive in the facility and/or represent systemic failure that affected or has the potential to affect a large portion or all of the facility's residents. Widespread scope refers to the entire facility population, not a subset of residents or one unit of a facility. In addition, widespread scope may be identified if a systemic failure in the facility (e.g., failure to maintain food at safe temperatures) would be likely to affect a large number of residents and is, therefore, pervasive in the facility.

Id. pt. IV.C.

315. "*Immediate jeopardy* means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

316. CMS defines this level of severity as:

> [N]oncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. This does not include a deficient practice that only could or has caused limited consequence to the resident.

CTRS. FOR MEDICARE & MEDICAID SERVS., SOM APP. P, *supra* note 296, pt. IV.B.

317. CMS defines this level of severity as:

> [N]oncompliance that results in no more than minimal physical, mental and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his/her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.

Id.

Remedies can be imposed for any nursing home that is not in substantial compliance;[319] however, customarily, remedies are *only* imposed for nursing homes that have deficiencies at a scope and severity level greater than A.[320] The greater the scope and severity of the deficiencies, the more likely the government will impose remedies.[321] Other factors considered in the selection of remedies are the relationship of the deficiencies resulting in noncompliance and the facility's prior history of noncompliance, both generally and specifically in reference to the current deficiencies.[322] If the states or CMS decide to impose remedies, there are three categories[323] of available remedies.[324]

These three categories of remedies include plan of correction, state monitoring, directed in-service training, denial of payment for new admissions, denial of payment for all individuals,[325] a per day civil money penalty (CMP) of

318. CMS defines this level of severity as "a deficiency that has the potential for causing no more than a minor negative impact on the resident(s)." *Id.*

319. 42 C.F.R. §§ 488.408(c). Both HHS and the states have the authority to impose remedies for noncompliance. *Id.* The states impose remedies for violations of Medicaid conditions of participation. *Id.* § 488.330(e)(1). The types of remedies by states vary, but are based on the remedies imposed for violations of the Medicare conditions of participation. States can add additional remedies, such as directed plan of correction or directed in-service training. *Id.* § 488.408(c).

320. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., SOM CH. 7, *supra* note 263, §§ 7304D, 7400E (noting that unless the deficiencies are at a scope and level A, the facility will be asked to submit a plan of correction to determine whether there is substantial compliance). Every facility is required to submit a plan of correction for deficiencies greater than a scope and severity of A. *Id.* A plan of correction is a remedy. *Id.*

321. 42 C.F.R. § 488.404.

322. *Id.* § 488.404(c).

323. If a facility has deficiencies rated at D or E, then HHS or the states must impose a Category 1 remedy. *Id.* § 488.408(c)(2). Category 1 remedies include directed plan of correction, state monitoring, and directed in-service training. *Id.* § 488.408(c)(1). If a facility has deficiencies rated at F, G, or H, then HHS or the states must impose a Category 2 remedy. *Id.* § 488.408(d)(2). Category 2 remedies include denial of payment for new admissions, denial of payment for all individuals, per day a civil money penalty (CMP) of $50 to $3,000, and per instance CMP of $1,000 to $10,000. *Id.* § 488.408(d)(1). Only HHS can impose denial of payment for all individuals. *Id.* § 488.408(d)(1)(ii). If a facility has deficiencies rated at I, HHS or the states may impose temporary management, in addition to Category 2 remedies. *Id.* § 488.408(e)(3). When the facility has one or more deficiencies rated at J, K, or L, HHS or the states must do one or both of the following: impose temporary management or terminate the Medicaid provider agreement. *Id.* § 488.408(e)(2)(i). Additionally, HHS or the states may impose a per day CMP of $3,050 to $10,000 or a per instance CMP of $1,000 to $10,000. *Id.* § 488.408(e)(2)(ii).

324. *Id.* § 488.408(b). HHS mandates that states establish remedies besides the termination of the provider agreement for non-state operated Medicaid nursing homes. *Id.* § 488.303(d). These remedies include temporary management, denial of payment for new admissions, CMPs, transfer of residents, closure of the facility and transfer of residents, and state monitoring. *Id.* In addition to these remedies, the states may impose directed plan of correction, directed in-service training, or alternative state-created remedies. *Id.* § 488.303(e). If the state creates alternative remedies, it must specify those remedies in its Medicaid plan and demonstrate to the satisfaction of HHS that the "alternative remedies are as effective in deterring noncompliance and correcting deficiencies as the [other] remedies . . . ." *Id.* § 488.303(f). Most states use the same remedies provided for under the Medicare Act.

325. *Id.* §§ 488.408(c)(1), d(1), e(1). Only HHS can impose this remedy. *Id.* § 488.408(d)(1)(ii).

$50 to $10,000, a per-instance CMP of $1,000 to $10,000,[326] temporary management, and termination of the Medicaid provider agreement.[327] The factors used to determine the amount of the CMP, include the facility's history of noncompliance (both generally and specifically in reference to the current deficiencies), whether the facility has repeated deficiencies, the relationship of the deficiencies resulting in noncompliance, the facility's culpability,[328] and the facility's financial conditions.[329]

In addition to the imposition of remedies, the state reports to CMS,[330] the state nursing home ombudsman, the physicians that work at the nursing home, the state skilled nursing facility administration licensing board, and the state Medicaid fraud and abuse control units.[331] CMS uses the states' findings to compile a quality rating, which is posted on the CMS Nursing Home Compare website.[332] The Nursing Home Compare website provides information regarding the overall quality of Medicaid certified nursing homes.[333] A nursing home's overall quality rating is based on information from the State's survey and certification reports and information submitted by the nursing home.[334]

Decisions made during the survey and certification process significantly affect nursing home behavior, and thus, will be useful in the fight against racial discrimination. For instance, according to Professor Robert Lee, the "Nursing Home Compare" website "is the nation's second most popular nursing home care site and is one of the most frequently visited sections of the [HHS] Web site."[335] This information is also used by *U.S. News & World Report* to publish a ranking of

326. *Id.* § 488.408(d)(1)(iii)–(iv).

327. *Id.* § 488.408(e)(1)(i)–(ii), (e)(2)(i).

328. *Id.* § 488.438(f). "*Culpability* . . . includes, but is not limited to, neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." *Id.* § 488.438(f)(4).

329. *Id.* § 488.438(f)(2).

330. The state enters the findings from the SOD into the CMS OSCAR database, which is available to the public. *See* Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., Nursing Home Quality Initiatives, http://www.cms.gov/NursingHomeQualityInits/ (last visited June 14, 2010) (making the findings available online).

331. 42 U.S.C. § 1395i-3(g)(5) (2006).

332. *See id.* § 1395i-3(g)(5) (requiring the publication of information from the surveys of nursing facilities). The information remains posted until the next annual survey is conducted.

333. Ctrs. for Medicare & Medicaid Servs., *supra* note 330.

334. Ctrs. for Medicaid & Medicare Servs., U.S. Dep't of Health & Human Servs., Nursing Home Compare, http://www.medicare.gov/NHCompare/Home.asp (last visited June 14, 2010). The quality rating of Medicaid certified nursing homes is based on three categories: health inspections, staffing levels, and quality measures. *Id.* (follow "Five-Star Quality Rating" hyperlink). 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.*

335. Lee et al., *supra* note 307, at 779.

America's best nursing homes[336] and by insurance companies to determine yearly hazard insurance premiums for nursing homes.[337]

The nursing home enforcement system is by no means perfect. Patient groups allege that survey teams miss deficiencies, while nursing home owners "argue that the current survey and enforcement system 'is an entirely subjective, process-oriented snapshot inspection system that focuses on punishment—not quality improvement.'"[338] Furthermore, in 2004, the Government Accountability Office reported testimony before the Senate Committee on Finance to the fact that "the magnitude of serious deficiencies that harmed nursing home residents remains unacceptably high, despite some decline."[339] Unlike Title VI enforcement, however, the problems of the nursing home enforcement system were not related to a lack of funding or lax enforcement. These deficiencies were a result of "insufficient and inexperienced survey staff, confusion about the regulations, inadequate state oversight of the survey process, and the predictable timing of surveys."[340]

Notwithstanding the deficiencies of the nursing home enforcement system, the Secretary and the states are actually investigating allegations of noncompliance and imposing remedies for noncompliance findings compared to allegations of Title VI violations.[341] In 2004, 3,159 federal and state CMPs were collected for a total of $21.6 million dollars.[342] As of 2009, no nursing home has been sanctioned for findings of noncompliance with Title VI.[343] Therefore, I argue that the

336. U.S. News & World Report, Best Nursing Homes Plus Assisted Living Facilities, http://health.usnews.com/senior-housing (last visited June 14, 2010).

337. Currently in many states, such as Texas, Florida, and Illinois, many nursing homes are forced to operate without insurance or go out of business because insurance companies are unwilling to offer nursing homes with less than perfect compliance histories reasonable insurance rates. *See* Kendall Anderson, *Nursing Homes Pay Premium to Survive: Soaring Liability Costs Blamed for Closure of Nonprofit Care Centers*, DALLAS MORNING NEWS, July 25, 2002, at 21A (describing nursing homes in Texas that were forced to close due to "skyrocketing liability insurance premiums").

338. Lee et al., *supra* note 307, at 772. "An ongoing concern for . . . [the various] stakeholders is that the number of deficiencies varies substantially between states." *Id.*

339. U. S. GEN. ACCOUNTING OFFICE, PUB. NO. GAO-03-1016T, NURSING HOMES: PREVALENCE OF SERIOUS QUALITY PROBLEMS REMAINS UNACCEPTABLY HIGH, DESPITE SOME DECLINE 2 (2003) (statement of William J. Scanlon, Dir., Health Care Issues Before the Senate Committee on Finance), *available at* http://www.gao.gov/new.items/d031016t.pdf.

340. Lee et al., *supra* note 307, at 772. "Surveyors question the integrity of the inspection, political pressures to water down inspection findings, and the effectiveness of the enforcement process." *Id.*

341. *See* Charlene Harrington et al., *Variation in the Use of Federal and State Civil Money Penalties for Nursing Homes*, 48 THE GERONTOLOGIST 679, 684 tbl.2 (2008) (reporting the 2004 CMPs imposed by HHS and states for noncompliance); Yearby, *supra* note 8, at 433, 474–75 (discussing the lack of Title VI enforcement).

342. *See* Harrington et al., *supra* note 341, at 684 tbl.2.

343. *See* Yearby, *supra* note 8, at 474–75 (showing that complaints are resolved through voluntary commitments to cease and desist discriminatory practices, rather than official Title VI sanctions).

integration of civil rights nursing with the nursing home enforcement system can be used to put an end to racial inequities.

C. Addressing Access and Quality Inequities Through the Nursing Home Enforcement System

Since 1965, nursing homes have improved the quality of care provided residents, while nursing homes never fully racially integrated or actively sought African American patients.[344] Because government agencies charged with the responsibility of enforcing civil rights laws have neglected their duties, in this sector, the time has come to invigorate Title VI enforcement by integrating it into the nursing home enforcement system.

For example, Medicaid conditions of participation include requirements for admission policies.[345] The conditions prohibit racial discrimination or exploitation of Medicaid patients solely based on their payment status.[346] As discussed in Part II, neither the Secretary nor the states enforce this condition and regulate the admissions practices of nursing homes.[347] Thus, nursing homes remain free to admit and deny whoever they choose, which empirical evidence shows is often linked to race.

The Medicaid admission requirements, however, do provide that "States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in th[e] [HHS regulation], to prohibit discrimination against individuals entitled to Medicaid."[348] I suggest that states use this authority to require nursing homes to submit yearly reports regarding the race of all patients who sought admission to the nursing home, including those denied admission.

Like Tennessee, every state should require nursing homes to develop and maintain a public waiting list of persons requesting admission to the nursing home.[349] This information should be submitted to the State as part of the nursing homes survey and certification process.[350] If the nursing home's admission report shows a trend in denial of admission based on race, this information should be

344. *See* SMITH, *supra* note 12, at 243, 264–67 (indicating that although Medicare and Medicaid have dramatically increased federal funding of health care since 1965, nursing homes remain highly segregated). The only change was the removal of blatant discriminatory advertising. *Id.* at 236.

345. 42 C.F.R. § 483.12(d) (2009).

346. *See* 42 U.S.C. § 1396r(c)(4)(A) (2006 & West. Supp. 2009) (prohibiting nursing homes from establishing and maintaining separate policies regarding transfer, discharge, and the provision of services).

347. *See supra* Part II.B.2.

348. 42 C.F.R. § 483.12(d)(4).

349. TENN. COMP. R. & REGS. 1200-13-01-.08 (2009).

350. Although this will not address steering by hospital discharge planners, it will begin to address race based admission decisions made by nursing homes.

published on the Nursing Home Compare website.[351] Additionally, HHS should impose remedies.

I also suggest that when the survey team visits a nursing home it should also monitor the quality of care provided based on race. Compliance with Title VI is not a condition of participation.[352] Nevertheless, the purpose of the Medicaid conditions of participation, which includes ensuring that residents of nursing homes receive quality care, is inextricably tied to race.[353] Studies show that the lower quality of care provided to elderly African Americans is due to racial inequities.[354] Thus, by limiting compliance with the conditions of participation to issues of quality and payment, the Secretary and the states have missed a significant factor that causes noncompliance: race.

To comply with the purpose of the Medicaid conditions of participation, the Secretary and the states should incorporate a review of nursing homes' compliance with the Medicaid conditions of participation, together with racial inequities in nursing home care. Incorporating a review of racial inequities will not impose an additional administrative burden on surveyors, because they already collect racial data.

A nursing home is required to complete a RAI for all patients upon admission and whenever there is significant change in the resident's condition.[355] The form also includes information about the resident's race.[356] This information is recorded on the RAI is coded and transmitted to the minimum data set (MDS).[357] The MDS information is used to compile reports, such as the facility quality measure

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351. To determine if the nursing home is discriminating in admissions, the waiting list will have to be compared to the medical records of patients admitted to the nursing home. If those on the waiting list who are minorities remain on the list, while Caucasians are admitted, then this supports a finding of discrimination.

352. *See* 42 C.F.R. § 483.75(c) (explaining that although additional nondiscrimination "regulations are not in themselves considered requirements . . . , their violation may result in the termination or suspension of . . . [f]ederal funds").

353. Yearby, *supra* note 247, at 986.

354. SMITH, *supra* note 12, at 265–67.

355. 42 C.F.R. § 483.20(b).

> The nursing home quality measures come from resident assessment data that nursing homes routinely collect on the residents at specified intervals during their stay. These measures assess the resident's physical and clinical conditions and abilities, as well as preferences and life care wishes. These assessment data have been converted to develop quality measures that give consumers another source of information that shows how well nursing homes are caring for their resident's physical and clinical needs.

Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., Quality Measures Nursing Home Quality Initiatives, http://www.cms.gov/NursingHomeQualityInits/10_NHQIQuality Measures.asp (last visited June 14, 2010).

356. *See* 42 C.F.R. § 483.20(b)(i) (detailing the requirements of the resident assessment instrument, including the patient's demographic information).

357. *Id.* § 483.20(f). MDS data is recorded in the MDS Repository and available to the public, so long as that information is not resident-identifiable. *Id.* § 483.20(f)(5)(i).

indicator report, which are used during the survey and certification process to determine whether the care provided to individual residents conforms to the Medicaid requirements.[358] In addition to using the MDS to compile facility quality measure and indicator reports, I suggest that the state's use the race information in the MDS to track individual patient care based on race. If the care provided to minorities does not meet the requirements of Medicaid, then the nursing home should be cited for noncompliance and fined.

In addition to this review of individual patient's care, I recommend that the government track the care given to different racial groups by using race information in the MDS to link quality with race. The team should collect and review racial data of current and past residents to compare the quality of care provided African American and Caucasian patients residing in the same facility.[359] Each time a facility is found to provide disproportionately poor care to African Americans, it should be cited for violating Medicaid and fined. To avoid fines and public humiliation, nursing homes would have to equalize the quality of care provided to African Americans.

The survey team can accomplish this goal by simply using the same regulations and citing the nursing home if the care provided is poor for minorities, such as African Americans. Not only does this fit within the requirements of current regulations concerning quality, it is also consistent with the spirit of the Medicaid Act, which explicitly mandates the government to provide medical assistance to elderly individuals who qualify for Medicaid in the same "amount, duration, or scope . . . made available to any other such individual."[360]

If the racial inequity in the provision of care was such that African Americans were harmed then the nursing home should be cited for actual harm. For example, a study showed that late-stage pressure sores are more common to African Americans, while early stage pressure sores are more common to Caucasians.[361] The higher rates of late-stage pressure sores in African Americans are because they are commonly underdiagnosed.[362] Thus, Caucasians receive treatment before the pressure sore becomes too severe, while African Americans and other minorities suffer without treatment until the pressure sore becomes irreparable.[363] This is a

358. CTRS. FOR MEDICARE & MEDICAID SERVS., SOM APP. P, *supra* note 296, pts. I, II.B.1. During the survey and certification process, the states use an RAI to check the nursing home's MDS information for errors. *Id.*

359. Because data of race have just become available, it may take time to obtain enough data to compare past and current residents.

360. 42 U.S.C. § 1396a(a)(10)(B)(i) (2006).

361. Fennell et al., *supra* note 6, at 175–76.

362. *Id.* at 176.

363. *See id.* (inferring that because African Americans suffer from disproportionately greater late-stage pressure sores, they are not receiving as immediate care as Caucasian patients in the same condition). Note that pressure sores can cause a variety of complications if left untreated, such as infection to the blood, heart, and bones; amputation; prolonged bedrest; or death. *See* DEP'T OF REHAB.

perfect example of actual harm suffered unequally by African American nursing home residents. The nursing home should be cited for a F, G, or H deficiency and should be fined between $50 to $3,000 per day or $1,000 to $10,000 per instance.[364] In addition to fines, the information should be posted on the Nursing Home Compare website.

When African Americans are seriously harmed, such as being hospitalized due to poor care, the nursing home should be cited for immediate jeopardy. A recent study found that African American nursing home residents were more likely than Caucasian residents to be hospitalized for "dehydration, poor nutrition, bedsores, and other aliments because of a gap in the quality of in-house medical care" in nursing homes.[365] This is a perfect example of an immediate jeopardy situation and in which African Americans unequally suffer serious harm. The nursing home should be cited for a J, K, or L deficiency and fined for these deficiencies should range between $3,050 to $10,000 per day or $1,000 to $10,000 per instance.[366] In addition to fines, the information should be posted on the Nursing Home Compare website. To avoid fines and public humiliation, nursing homes would have to equalize the quality of care provided to African Americans.

Some may argue that it will be too difficult to link poor outcomes with race. However, when surveyors review the care provided by a nursing home to residents they are able to determine whether the poor outcomes were unavoidable. Thus, the surveyors will only have to look at the resident's race and determine whether African American residents suffer more avoidable poor outcomes when compared with Caucasian residents.

Additionally, some may argue that there is no way to track racial inequities in the quality of care when there is low racial mix in residents. This concern can be alleviated. Currently, when inspecting nursing homes, the government determines nursing home deficiencies based on all the nursing homes in the country and all nursing homes in the state in which the nursing home is located.[367] If the federal government uses the racial classification information found in the MDS, then it will have national and state racial inequity data.[368] Even if the nursing home only has a small number of African American residents there will be a national and state standard of care based on race that can be used to determine whether these nursing

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MED., UNIV. OF WASH. MED. CTR., TAKING CARE OF PRESSURE SORES (2007), *available at* http://sci.washington.edu/info/pamphlets/takecare_pressuresores.pdf (listing symptoms and complications caused by pressure sores).

364. *See supra* note 323 and accompanying text.

365. Spinner, *supra* note 123.

366. *See supra* note 323 and accompanying text.

367. *See generally* Medicare.gov, Nursing Homes: About Nursing Home Inspections, http://www.medicare.gov/nursing/AboutInspections.asp (last visited June 14, 2010) (indicating that state officials conduct inspections an average of once per year to determine whether nursing homes within their state comply with minimum national standards under Medicare and Medicaid).

368. *See supra* notes 355–57 and accompanying text.

homes should be cited for providing poor quality care. If so, they should be sanctioned accordingly.

As Professors Sara Rosenbaum and Joel Teitelbaum note, "it no longer makes sense to divide the world of enforcement when the overall goal is the systemic improvement of program performance."[369] By integrating these systems, the government "would make clear that a particular practice is desirable not only because it improves the racial equality of programs but also because it improves the quality of health care for persons who are the intended beneficiaries of the programs."[370] This is further supported by the seminal Institute of Medicine study, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*,[371] that stated "[b]y establishing both racial equality and program quality improvement as two inextricably linked goals . . . the federal government would immeasurably strengthen its hand in the setting of prospective standards of conduct."[372]

There are several approaches one could take to induce the government to integrate these systems. One approach is administrative. African Americans could pursue a petition for rulemaking to require HHS to integrate investigations of racial inequities with the current survey and certification process. Another approach would be more politically oriented and use grassroots or lobbying efforts, to force Congress to revise the NHRA to include enforcement of civil rights complaints. Yet, another approach would be litigation. African Americans could file class action lawsuits against the Secretary and the states for violating the Medicaid Act's "reasonable promptness" provision and the NHRA's requirements that a nursing home to provide quality care. Because Congress and HHS have focused on bigger issues such as economic recovery and universal health care coverage,[373] in my opinion the administrative and political approaches do not seem feasible.[374] Therefore, in this Article I will focus exclusively on the last option: the class action suit.

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369. Rosenbaum & Teitelbaum, *supra* note 18, at 250.

370. *Id.*

371. *See generally* INST. OF MED., *supra* note 9, at 285–89 app. B (describing the study and how it was performed).

372. Rosenbaum & Teitelbaum, *supra* note 18, at 250.

373. *See, e.g.*, David M. Herszenhorn & Robert Pear, *While Confident Health Care Will Pass This Year, Democrats Still Search for a Plan*, N.Y. TIMES, Jan. 29, 2010, at A11 (describing recent congressional focus on the economy and health care).

374. There has been no mention of civil rights concerning racial disparities in health care by the Obama Administration. The only discussion regarding civil rights enforcement has focused on voting rights, housing, employment, bank lending practices, and redistricting after the 2010 census. *See* Charlie Savage, *White House to Shift Efforts on Civil Rights*, N.Y. TIMES, Sept. 1, 2009, at A1 (noting that that the Civil Rights Division of the Justice Department is focusing on voting rights, housing, and hiring as part of "a major revival of high-impact civil rights enforcement against policies . . . where statistics show that minorities fare disproportionately poorly").

IV. USING THE MEDICAID ACT TO TRANSFORM THE SYSTEM

Most nursing homes now participate in the Medicaid program, and evidence shows that significant racial inequities in the provision of care due to racial discrimination persist.[375] Therefore, it seems reasonable to use compliance with the Medicaid Act and the NHRA as a means to rectify unequal quality of care provided African Americans when compared to Caucasians. Specifically, elderly African Americans and their advocates should file injunctive and declaratory § 1983 claims[376] asserting that the Secretary and the states have violated the Medicaid Act and the NHRA.[377]

Each case requires the certification of a class.[378] The first class would include African Americans who were delayed transfer or denied admission. This class would assert that the states and Secretary have failed to fulfill the mandates of the Medicaid Act's "reasonable promptness" provision, which requires that Medicaid patients receive reasonably prompt medical assistance and includes nursing home care.[379] The second class would include African Americans who received poor quality care and challenge the Secretary and the states compliance with the NHRA's requirements for nursing homes, which mandates that the states and Secretary ensure that nursing homes provide residents with quality nursing care.[380]

Before courts review the substance of either case, African Americans will have to show that there is a private right of action under 42 U.S.C. § 1983 by fulfilling the test established in *Blessing v. Freestone*.[381] Several circuits have

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375. Mor et al., *supra* note 25, at 237–38; *see* Avery Comarow, *Best Nursing Homes: Behind the Rankings*, U.S. NEWS & WORLD REP., Jan. 11, 2010, http://health.usnews.com/articles/health/best-nursing-homes/2010/01/11/best-nursing-homes-behind-the-rankings.html (noting nearly all nursing homes today participate in the Medicare and Medicaid programs).

376. *See* 42 U.S.C. § 1983 (2006) ("Every person who, under color of any statute . . . subjects, or causes to be subjected, any citizen . . . to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . . .").

377. Violations of the NHRA are actionable under 42 U.S.C. § 1983. *See, e.g.*, Grammer v. John J. Kane Reg'l Ctrs.-Glen Hazel, 570 F.3d 520, 522, 525, 532 (3d Cir. 2009) (ruling that the NHRA, 42 U.S.C. § 1396r, provided a private right of action under § 1983).

378. *See* FED. R. CIV. P. 23(a)–(b) (describing the prerequisite for certifying a class and the types of class action suits).

379. 42 U.S.C. § 1396a(a)(8), (10) (2006 & West Supp. 2009).

380. *See Id.* §§ 1396r(b)(1)(A) (requiring that a nursing facility provide care consistent with the maintenance or enhancement of its patients' quality of life).

381. *See* 520 U.S. 329, 340–41 (1997). The Court in *Blessing* held that plaintiffs seeking redress through 42 U.S.C. § 1983 must assert the violation of a federal *right*, as opposed to merely the violation of federal *law*. *Id.* at 340. The Court required that the plaintiff demonstrate the presence of three factors:

> First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so 'vague and amorphous' that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States.

Id. (citations omitted).

already ruled that Medicaid's "reasonable promptness" provision provides a private right of action under 42 U.S.C. § 1983, applying this test.[382] The Third Circuit, the only court that has ruled on the right to sue under the specific NHRA section discussed in this Article, ruled that the NHRA provides a private right of action.[383] Based on past precedent, the courts should review the substance of both cases.[384]

To win the case and obtain an injunction, plaintiffs still must show that they have suffered irreparable harm based on the empirical evidence specific to their state.[385] Unlike other civil rights cases, in the proposed litigation proof of specific instances of delays, denials of admission, and disparities in quality by specific nursing homes due to disparate treatment is unnecessary because this case is based on the systematic failures of the Secretary and the states to devise a system that allows for Medicaid patients to attain reasonably prompt access to quality nursing home care. Thus, to have standing a class of plaintiffs must show that they have been denied reasonably prompt access to quality nursing homes by providing empirical data regarding the delays experienced by other state residents as was used in *Linton ex rel. Arnold v. Commissioner of Health & Environment*.[386] Currently, the only states that have detailed empirical research regarding delays and denials of admission are North Carolina and New York.[387] Yet, there is already clear and convincing national and state data that there are racial disparities in admission to and the provision of quality nursing home care.[388]

Furthermore, to obtain an equitable remedy such as injunctive relief, the plaintiffs must show that they will win on the merits of the case.[389] Based on case precedent, the plaintiffs should prevail on the merits. Over the last thirty years, Medicaid patients have filed a number of § 1983 claims to challenge racial

382. *See* cases cited *supra* note 51.

383. Grammer v. John J. Kane Reg'l Ctrs.-Glen Hazel, 570 F.3d 520, 522, 525, 532 (3d Cir. 2009).

384. *See* Doe v. Kidd, 501 F.3d 348, 355–56 (4th Cir. 2007) (ruling that there was a private right of action under § 1983 in 42 U.S.C. § 1396a(a)(8)); Watson v. Weeks, 436 F.3d 1152, 1159 (9th Cir. 2006) (ruling that there was a private right of action under § 1983 in 42 U.S.C. § 1396a(a)(10)); Sabree *ex rel.* Sabree v. Richman, 367 F.3d 180, 183 (3d Cir. 2004) (holding that an analysis based upon other cases "compels the conclusion that the provisions invoked by plaintiffs—42 U.S.C. §§ 1396a(a)(8), 1396a(a)(10), and 1396d(a)(15)—unambiguously confer rights vindicable under § 1983").

385. Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly, 572 F.3d 644, 651 (9th Cir. 2009) (quoting Winter v. Natural Res. Def. Council, Inc., 129 S. Ct. 365, 374 (2008)).

386. 779 F. Supp. 925, 927–28, 935–36 (M.D. Tenn. 1990). In *Linton*, the class of plaintiffs sought to enjoin a Tennessee policy, which allowed nursing homes to limit the number of beds used for Medicaid patients. *Id.* at 927. The Court held that the plaintiffs possessed the requisite standing because they were able to prove that the policy had a disparate impact on minorities. *Id.* at 932.

387. *See* Yearby, *supra* note 8, at 457 n.181 (noting that, as of 2007, only North Carolina and New York have shown that African Americans experience delays in transfer to quality nursing homes due to their race).

388. *See supra* Part I.B–C.

389. *Indep. Living Ctr. of S. Cal.*, 572 F.3d at 651.

inequities and quality of care violations in nursing home care.[390] In a majority of the cases, the plaintiffs were able to force the Secretary and the states to implement new rules and regulations to address racial inequities and quality of care violations.[391]

Filing cases such as these can be timely and costly.[392] Though they will not eliminate all of the race-based decision-making that pervades the nursing home system, this may be the best option to induce the Secretary and the states to significantly improve the quality of nursing home care for all African Americans compared to the infinitesimal gains made when individual complainants prevail.

A. Private Right of Action Under § 1983

In order to bring a § 1983 claim, plaintiffs must show that they fulfill the standard announced in *Blessing*.[393] The *Blessing* standard requires that: 1) Congress intended to confer a benefit on the plaintiff; 2) "the right . . . is not so 'vague and amorphous' that its enforcement would strain judicial competence;" and 3) the statue unambiguously imposes a mandatory binding obligation on the states.[394] The Supreme Court further refined the language of the first prong of *Blessing* in *Gonzaga University v. Doe*,[395] requiring that there be explicit rights creating language in the statute in question.[396] If a plaintiff fulfills the requirements of the refined *Blessing* test, there is a presumption that the plaintiff has a private right of action under § 1983.[397] The government can overcome this presumption if it can show that Congress created a comprehensive administrative scheme that is incompatible with individual enforcement under § 1983.[398] When applying the

390. *E.g.*, *In re* Estate of Smith v. Heckler, 747 F.2d 583, 585 (10th Cir. 1984); Taylor v. White, 132 F.R.D. 636, 639 (E.D. Pa. 1990); *Linton*, 779 F. Supp. at 927.

391. *E.g.*, *Heckler*, 747 F.2d at 591 (commanding the Secretary "to promulgate regulations [that] will enable her to be informed as to whether the nursing facilities receiving federal Medicaid funds are actually providing high quality medical care"); *Linton*, 779 F. Supp. at 936 (ordering the Commissioner to submit a plan to the court that will redress the disparate impact of minority Medicaid patients).

392. *See* Deborah R. Hensler, *Revisiting the Monster: New Myths and Realities of Class Action and Other Large Scale Litigation*, 11 DUKE J. COMP. & INT'L L. 179, 189, 205 (2001) (describing both the cost and time involved for plaintiffs in class action lawsuits). Pursuing a class action will not improve the quality of care provided to private-pay, elderly African Americans residing in nursing homes not participating in the Medicare or Medicaid programs. However, it will provide assistance to some of the most vulnerable, elderly, indigent African Americans.

393. 520 U.S. 329, 340–41 (1997).

394. *Id.* (citing Wright v. City of Roanoke Redevelopment & Hous. Auth., 479 U.S. 418, 430–32 (1987)).

395. 536 U.S. 273 (2002).

396. *Id.* at 283 (requiring unambiguous rights, not vague benefits or interests).

397. *Id.* at 284; *Blessing*, 520 U.S. at 341.

398. *Blessing*, 520 U.S. at 341; *see also Gonzaga*, 536 U.S. at 284–86 ("[Where the text and structure of a statute provide no indication that Congress intends to create new individual rights, there is no basis for a private suit . . . ."). Although this appears to create another hurdle for private parties, in 1997 the Supreme Court noted that it has only twice found that an administrative scheme was sufficient

refined *Blessing* test to the Medicaid Act's "reasonable promptness" provision and the NHRA's requirements for nursing homes, the court should find that the plaintiffs have a right to sue under § 1983.

The requirements of the Medicaid Act's "reasonable promptness" provision are specified in 42 U.S.C. § 1396a(a)(8) and (10). They require states to furnish all Medicaid patients with medical assistance, such as nursing home services for the elderly,[399] with "reasonable promptness."[400] Six circuits have already ruled that the "reasonable promptness" provisions in 42 U.S.C. § 1396a(a)(8) and (10) provide a private right of action.[401]

For instance, in *Doe v. Kidd*,[402] the court held that an individual with developmental disabilities could sue South Carolina for the state's failure to provide temporary residential habilitation services approved in her plan of care with "reasonable promptness."[403] The court ruled that the "reasonable promptness" provision in 42 U.S.C. § 1396a(a)(8) was phrased in terms of the individuals benefited, that the language specifically focuses on the individuals benefited, and that the provision evidenced a clear intent by Congress to create a federal right.[404] Additionally, the court found that the "reasonable promptness" provision was clear and explicit that nursing home services had to be provided and was worded in

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to supplant claims under § 1983. *Blessing*, 520 U.S. at 347 (citing Smith v. Robinson, 468 U.S. 992 (1984); Middlesex County Sewerage Auth. v. Nat'l Sea Clammers Ass'n, 453 U.S. 1 (1981)). In *Middlesex*, the Court noted that private parties had the right to seek federal review under the administrative scheme, thus no private right of action was necessary under § 1983. 453 U.S. at 13–14. In *Smith*, the Court held that "Congress intended the EHA to be the exclusive avenue through which a plaintiff may assert an equal protection claim to a publicly financed special education." 468 U.S. at 1009, *superseded by statute*, Handicapped Children's Protection Act of 1986, Pub. L. 99-372, 100 Stat. 796, *as recognized in* Fontenot v. Louisiana Bd. of Elementary & Secondary Educ., 805 F.2d 1222, 1224 (5th Cir. 1986). Some federal courts often ignore this requirement in their analysis of § 1983 or summarily dismiss the requirement. *See* Watson v. Weeks, 436 F.3d 1152, 1162 (9th Cir. 2006) (quoting Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 523 (1990) (noting that the existence of state administrative procedures ordinarily does not prevent a § 1983 claim)); Sabree *ex rel.* Sabree v. Richman, 367 F.3d 180, 193 (3d Cir. 2004) ("[T]here is a substantial burden on a state seeking to establish that Congress has provided a comprehensive remedial scheme with which individual actions cannot be reconciled."); Rolland v. Romney, 318 F.3d 42, 51–56 (1st Cir. 2003) (analyzing whether the NHRA created a private right of action enforceable under § 1983 without discussing whether the statute's administrative scheme is compatible with enforcement under § 1983).

399. *See* 42 U.S.C. § 1396a(a)(10)(D), 1396d(a) (2006) (detailing the requirements of state plans for medical assistance, including nursing facilities for the elderly). If a Medicaid patient does not receive nursing home care in a reasonably prompt manner, the patient has the opportunity to have a fair hearing before the state agency. *Id.* § 1396a(a)(3).

400. *Id.* § 1396a(a)(8).

401. *See* cases cited *supra* note 51.

402. 501 F.3d 348 (2007).

403. *Id.* at 351, 356.

404. *Id.* at 356. The court noted that reasonable promptness in terms of a determination of eligibility to receive services was forty-five or ninety days, depending on the applicant. *Id.* This time length, however, applies to determination of eligibility, not actual access to services. *Id.* The time length that constitutes reasonable promptness in accessing services has not been defined.

"mandatory rather than precatory terms . . . ."[405] Finally, the court held that "the Medicaid Act does not explicitly forbid recourse to § 1983" and that the administrative rights granted in 42 U.S.C. § 1396a(a)(3) were not incompatible with individual actions under § 1983.[406] Based on *Kidd* and the rulings by five other circuits, it is clear that the "reasonable promptness" provision found in 42 U.S.C. § 1396a(a)(8) and (10) meet the requirements of the refined *Blessing* test. Therefore, African Americans suing states and the Secretary for failure to provide nursing home care in a reasonably prompt manner should not have any problem showing that they have a private right under § 1983.

The relevant NHRA requirements are found in 42 U.S.C. § 1396r(a)(1), (b), (f)(1), and (g)(1)(A). Sections 42 U.S.C. § 1396r(a)(1) and (b) require a nursing home to "care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident" and "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being or each resident . . . ."[407] Sections 42 U.S.C. § 1396r(f)(1) and (g)(1)(A) require the Secretary and the states to ensure that nursing homes are complying with 42 U.S.C. § 1396r(a)(1) and (b). There have only been four opinions issued after the *Gonzaga* case regarding the NHRA and § 1983. Courts in three of the cases found a private right of action, while the third court summarily dismissed the private right under 42 U.S.C. § 1983 without applying *Blessing* or *Gonzaga*.[408] The case that is germane to African Americans' claims concerning quality of care violations in nursing homes is *Grammer v. John J. Kane Regional Centers-Glen Hazel*[409] because it analyzes 42 U.S.C. § 1396r(b) of the NHRA.

In *Grammer*, the Court of Appeals for the Third Circuit ruled that the NHRA provided a private right of action under § 1983.[410] The daughter of a woman who died in a nursing home brought an action against a nursing home operated by the county for wrongful death.[411] The suit alleged that the nursing home failed to provide quality nursing home care as required by the NHRA and thus caused the resident's death.[412] The court found that Grammer's mother was an intended

405. *Id.*

406. *Id.*

407. 42 U.S.C. §§ 1396r(b)(1)(A), (b)(2) (2006).

408. *Compare* Joseph S. v. Hogan, 561 F. Supp. 2d 280, 299–303 (E.D.N.Y. 2008) (ruling that § 1396r(e)(7) provided a private right of action under § 1983), *and* Rolland v. Romney, 318 F.3d 42, 51–56 (1st Cir. 2003) (ruling that several sections of NHRA, including 42 U.S.C. § 1396r(b), provide a private right of action under § 1983), *with* Sparr v. Berks County, No. CIV.A. 02-2576, 2002 WL 1608243, at *1–*3 (E.D. Pa. July 18, 2002) (summarily finding no private right of action under § 1396r without applying the *Blessing* or *Gonzaga* factors).

409. 570 F.3d 520 (3d Cir. 2009).

410. *Id.* at 532.

411. *Id.* at 522.

412. *Id.*

beneficiary of the NHRA because she was a Medicaid recipient and a nursing home resident, satisfying the first *Blessing* factor.[413] Relying on an opinion of the Court of Appeals for the Second Circuit,[414] the court reasoned that although the language is couched in terms of the duties of the nursing home, the intended beneficiaries of the services were Medicaid beneficiaries.[415] The court also ruled that the second and third *Blessing* factors were met.[416] According to the court, the rights language was clearly delineated with *must provide* and *must maintain*, and the repeated use of *must* unambiguously binds the states and nursing homes.[417]

Additionally, the court ruled that the 42 U.S.C. § 1396r(b) of the NHRA contained explicit rights creating language, the last requirement in the refined *Blessing* test.[418] Relying on prior decisions regarding the NHRA,[419] the court found that the language was mandatory and the provisions were clearly "phrased in terms of the persons benefitted."[420] Although the section is phrased in terms of state and nursing home responsibilities, the statute is "concerned with 'whether the needs of any particular person have been satisfied,' not solely with an aggregate institutional policy and practice."[421] Moreover, "Congress explicitly included the word 'rights' [in the NHRA] when identifying the . . . entitlements of nursing home residents, compared to other sections of the Medicaid Act, such as the "reasonable promptness" provision.[422]

Finally, the court reviewed the structure of the statute to determine whether it contained rights-creating language. The court reviewed the structural elements of the Medicaid Act, which "speak in terms of an 'agreement between Congress and a particular state.'"[423] Applying a balancing test between the strength of the specific language of the statutory provisions at issue and the larger structural elements of the statute that the court had previously created, it found that the structure could not neutralize the rights-creating language.[424] Specifically, the court stated that "[t]he

413. *Id.* at 527.

414. *Id.* (citing Concourse Rehab. & Nursing Ctr. Inc. v. Whalen, 249 F.3d 136, 143–44 (2d Cir. 2001) (ruling that 42 U.S.C. § 1396r (NHRA) does not provide nursing homes a private right of action under § 1983)).

415. *Grammer*, 570 F.3d at 527.

416. *Id.* at 528.

417. *Id.*

418. *Id.* at 531.

419. *See id.* at 529 (citing Sabree *ex rel.* Sabree v. Richman, 367 F.3d 180, 190 (3d Cir. 2004) (ruling that the Medicaid Act's reasonable promptness provision conferred a private right of action under § 1983)).

420. *Id.* at 529–30.

421. *Id.* at 530 (quoting Blessing v. Freestone, 520 U.S. 329, 343 (1997)).

422. *Id.* at 531.

423. *Id.* (quoting *Sabree*, 367 F.3d at 191).

424. *Id.* at 531–32. The court created this balancing test in *Sabree*, in which the court ruled that the reasonable promptness provision conferred a private right of action under § 1983. *See Sabree*, 367 F.3d at 192–94.

language used throughout the [NHRA] is explicitly and unambiguously rights-creating, despite the countervailing elements of the statute. The larger statutory structure, therefore, does not neutralize the rights-creating language contained throughout the [NHRA]."[425]

In the proposed case by African Americans, the class should rely on the *Grammer* ruling to support a claim of a private right of action under § 1983. The Secretary and the states will be unable to rebut this presumption because the remedial scheme to address instances of quality of care violations is limited and does not supplant § 1983. More specifically, the NHRA administrative scheme does not provide remedies for Medicaid patients.[426] Furthermore, when compared to one of the only cases in which the Supreme Court ruled that the state rebutted the presumption of the private right of action under § 1983, *Middlesex County Sewerage Authority. v. National Sea Clammers Ass'n*,[427] the remedial scheme in the NHRA is almost non-existent and does not constitute a comprehensive remedial scheme.

In *Middlesex County*, the Supreme Court ruled that the remedial scheme was comprehensive evidencing of Congressional intent to foreclose a private right of action under § 1983.[428] The remedial scheme in *Middlesex County* contained unusually elaborate enforcement provisions, granting private individuals the right to seek judicial review for complaints against the federal government and to seek injunctions to enforce the statutes in the United States Courts of Appeals.[429] Unlike the scheme in *Middlesex County*, Medicaid patients have no right to remedies under the NHRA.[430] Thus, based on the rulings in *Grammer* and *Middlesex County*, African Americans should be able to sue the Secretary and the states for violations of the NHRA's requirements of nursing homes.

B. Merits of the Medicaid Case

The federal and state governments jointly fund and regulate health care entities, such as nursing homes, under the Medicaid Act. The Secretary implements regulations governing the Medicaid Act, while each state submits detailed plans to the secretary for approval and funding.[431] Every state's plan is different; however,

425. *Grammer*, 570 F.3d at 532.

426. *Id.* at 532. Patients can only send complaints to the state alleging NHRA violations, which the state then investigates. 42 C.F.R. § 488.332 (2009). However, there are no remedies available when the state fails to address violations by nursing homes. *See id.* §§ 488.320, .335 (stating that the state is responsible for investigating complaints, but giving no redress for individual grievances or inadequate state survey performance).

427. 453 U.S. 1 (1981).

428. *Id.* at 18–21.

429. *Id.* at 13–14.

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

431. 42 U.S.C. § 1396c (2006).

every state plan must include provisions granting Medicaid patients reasonably prompt access to medical assistance.[432] This access includes reasonably prompt admission to nursing homes that provide nursing and rehabilitative services to the indigent elderly.[433] If the state is not providing reasonably prompt access, the Secretary has a duty to sanction the state based on its look-behind authority.

1. Reasonable Promptness

Many courts have presumed that reasonably prompt access to "medical assistance" includes provision of services that a state is obligated to provide,[434] while other courts have limited it to adequate financial support.[435] The Supreme Court has not ruled on this distinction. Therefore, to succeed on the merits of the case, African Americans either need to submit the claim to circuits that have ruled the "reasonable promptness" provision requires the state to provide services or link the failure to access nursing home services to the failure of the state to provide adequate financial payments. Plaintiffs in *Linton* successfully provided evidence of both.

In *Linton*, elderly African Americans brought lawsuits charging that Tennessee's Medicaid bed certification policies violated the "reasonable promptness" provision of Medicaid.[436] Specifically, they asserted that the states' policies for Medicaid bed certification allowed nursing homes to deny Medicaid patients' admission because the nursing home did not have any Medicaid beds, but if a more desirable Medicaid patient sought admission then another Medicaid bed would be certified.[437] Some patients were delayed for over a year.[438] This was

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432. *Id.* § 1396a(a)(8).

433. *See id.* § 1396a(a)(10) (including nursing facilities as a type of "medical assistance" required by state plans).

434. *See, e.g.*, S.D. *ex rel.* Dickson v. Hood, 391 F.3d 581, 597 (5th Cir. 2004) ("[W]e conclude that [the state Medicaid agency] violated the Medicaid Act by denying [the plaintiff] a service described in § 1396d(a) that is necessary for ameliorative purposes . . . ."); Doe v. Chiles, 136 F.3d 709, 715 (11th Cir. 1998) ("The plain language of the provision's reasonable promptness clause is clearly intended to benefit Medicaid-'eligible individuals' . . . .").

435. *E.g.*, Westside Mothers v. Olszewski, 454 F.3d 532, 540 (6th Cir. 2006) (explaining that Medicaid requires states to provide eligible recipients with "a prompt determination of eligibility and a prompt payment" to obtain medical services); Bruggeman *ex rel.* Bruggeman v. Blagojevich, 324 F.3d 906, 910 (7th Cir. 2003) (same); Clark v. Richman, 339 F. Supp. 2d 631, 642 (M.D. Pa. 2004) (same); Sanders *ex rel.* Rayl v. Kan. Dep't of Soc. & Rehab. Servs., 317 F. Supp. 2d 1233, 1250 (D. Kan. 2004) (same).

436. Linton *ex rel.* Arnold v. Comm'r of Health & Env't, 779 F. Supp. 925, 927–28 (M.D. Tenn. 1990).

437. *Id.* at 928.

438. *See id.* (stating that the plaintiff was diagnosed as requiring nursing home treatment in July 1987, but was still delayed a bed in December 1989).

evidence that the patients were not provided reasonably prompt access to services.[439]

Moreover, plaintiffs showed that Tennessee's financial support caused this delay in reasonably prompt access.[440] As a way to decrease the money paid to nursing homes, Tennessee granted nursing homes total discretion in the certification of beds for use by Medicaid patients.[441] Some nursing homes used this discretion to deny African American Medicaid patients admission because the nursing home did not have any Medicaid beds.[442] If, however, a Caucasian Medicaid patient sought admission, the nursing home would certify another bed for Medicaid use.[443] The court ruled for the plaintiffs holding that Tennessee's fiscal policy violated Medicaid's "reasonable promptness" provision because it delayed reasonably prompt access to medically necessary services.[444]

As in *Linton*, empirical data provided in Part I shows that states have again violated the "reasonable promptness" provision of the Medicaid Act.[445] African Americans are consistently delayed and denied reasonably prompt access to medically necessary nursing home services because nursing homes deny admission to African Americans.[446] Since the 1980s, several state studies have shown that African Americans are delayed by at least ten days in a transfer from the hospital to a nursing home.[447] This should satisfy courts that require proof that states have failed to provide actual access to nursing home care.

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439. *See id.* at 932–33, 936 (finding that Tennessee's limited bed policy for Medicaid patients has resulted in many patients being unable to obtain "proper nursing home care" entitled under the statute).

440. *See id.* at 931–32 (explaining that, although Medicaid law mandates that states set Medicaid payments at levels that will meet the costs necessary to adequately operate facilities, Tennessee's bed certification program permitted nursing home operators to prefer private-pay patients that pay higher rates than Medicaid patients).

441. *Id.*

442. *Id.* at 932 ("Because of the higher incidence of poverty in the [African American] population, and the concomitant increased dependence on Medicaid, a policy limiting the amount of nursing home beds available to Medicaid patients will disproportionately affect [African Americans].").

443. *See generally id.* ("[S]uch discrimination has caused a 'dual system' of long term care for the frail elderly: a statewide system of licensed nursing homes, [seventy] percent funded by the Medicaid program, serves [Caucasians]; while [African Americans] are relegated to substandard boarding homes [that] receive no Medicaid subsidies.").

444. *Id.* at 936. Coupled with their "reasonable promptness" argument, plaintiffs also submitted a claim for racial discrimination under Title VI on the basis of statewide data that indicated that "while [African Americans] comprise 39.4 percent of the Medicaid population [in Tennessee in 1987], they account for only 15.4 percent of those Medicaid patients who have been able to gain access to Medicaid-covered nursing home services." *Id.* at 932.

445. *See supra* notes 436–44 and accompanying text (discussing claims and empirical evidence presented in *Linton*); *supra* Part I (presenting empirical data on inequities in the promptness of treatment received by racial minorities).

446. *See* Falcone & Broyles, *supra* note 6, at 591–92 (showing that non-Caucasian patients experience much longer discharge delays than Caucasian patients, and suggesting discrimination as the cause).

447. *See supra* note 84.

These delays are a result of states' financial polices. Similar to the policies in *Linton*, the current Medicaid policies of the states have failed to provide reasonably prompt access to services. According to research studies, states, trying to keep down the costs of Medicaid, grant nursing homes great discretion in their admission practices and policies.[448] Thus in reality, the admissions decisions are left solely to the nursing home staff, who deny African Americans admission to nursing homes and deny African Americans reasonably prompt access to services.[449] Arguably, the state's failure to properly finance oversight of admissions policies at nursing homes causes African Americans to be denied access to nursing home services. This should satisfy courts that require proof that states have failed to provide adequate financial support to fulfill the mandates of the "reasonable promptness" provision. In order to prevail the plaintiffs must show that the delay was unreasonable.

These arguments would support a claim against the states, but not against the Secretary. The substance of the case against the Secretary is found in the "look behind" requirement.

2. Look-Behind Authority

The Medicaid Act authorizes the Secretary to fund state plans to provide "health care to needy persons" through agreements with private and public persons and institutions capable of providing such services.[450] In order to receive Medicaid funding, a state must submit a plan to the Secretary, which includes the method of "establishing and maintaining health standards" for health care facilities that will provide services to Medicaid recipients.[451] To ensure that the care provided is of sufficient quality, the state must determine annually whether a participating nursing home meets the requirements for continued participation in the program through the survey and certification process.[452]

Congress granted the Secretary the authority to "look behind" the state's determination of a nursing home's compliance with the state Medicaid plan.[453] Based on the "look behind" provision, if the Secretary found that the state plan was

448. Grabowski, *supra* note 92, at 462 (noting that states regulate the admission process by restricting the number of Medicaid certified nursing home beds).

449. *See id.* (identifying a positive correlation between increased nursing home admissions for African Americans and increased Medicaid expenditures for states, resulting in less pressure from state regulators to increase racial integration).

450. Harris v. McRae, 448 U.S. 297, 308 (1980); Yearby, *supra* note 8, at 484.

451. 42 U.S.C. § 1396a(a)(6), (9)(A) (2006 & West Supp. 2009).

452. 42 C.F.R. §§ 488.301, 488.308(a)–(b) (2009).

453. *See* 42 U.S.C. § 1396a(a)(33)(B) (authorizing the Secretary to "make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation" if the Secretary has cause to question the adequacy of a state's determination). This "look behind" provision was passed as part of the Omnibus Reconciliation Act of 1980, the same bill that created alternative sanctions to the termination of long-term care facilities. Pub. L. No. 96-499, § 916, 94 Stat. 2599, 2623–24 (1980).

deficient and the state failed to show that it had implemented an effective nursing home inspection program, the Secretary has to reduce the percentage of federal funds given to the state's Medicaid program.[454] Thus, independent of the states' mandate, the Secretary has an independent duty under Medicaid's "look behind" provision to review the states plan and findings regarding Medicaid patients' reasonably prompt access to nursing home care,[455] according to the court's decision in *In re Estate of Smith v. Heckler.*[456]

In *Heckler*, Medicaid patients residing in Colorado nursing homes brought a class action suit[457] against the Secretary.[458] The plaintiffs argued that the Medicaid Act created an entitlement for Medicaid patients to receive quality care and that the Secretary, therefore, has a duty to create a nursing home inspection system that centered on the provision of quality nursing care.[459] The Secretary argued that HHS had fulfilled the requirements of Medicaid by publishing advisory enforcement standards governing state inspection of Medicaid certified nursing homes.[460] Each sides' arguments centered on the duties of the Secretary under the Medicaid Act.

The Secretary argued that HHS fulfilled its duty by promulgating regulations and developing forms to be used by the states to certify the compliance of nursing homes.[461] However, according to the plaintiffs, these forms were deficient because the forms only required states to review the physical appearance of the facility and theoretical capability of a nursing home to render quality care, instead of regulating the actual care provided to patients in nursing homes, which according to the

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454. 42 U.S.C. § 1396b(g)(1).

455. *See id.* § 1396a(a)(33)(B) (codifying the grant of look-behind authority to the Secretary).

456. 747 F.2d 583, 589–90 (10th Cir. 1984).

457. *See In re* Estate of Smith v. O'Halloran, 557 F. Supp. 289, 290 (D. Colo. 1983) (establishing the facts of the claim in *Heckler*). The Plaintiffs brought this action under 42 U.S.C. § 1983, seeking remedies for alleged violations of their constitutional right to be provided quality care in nursing homes certified to participate in the Medicaid program. *Id.* The case was first filed on May 16, 1975, but did not go to trial until May 17, 1982. *Id.* at 290, 292.

458. *Id.* at 290. The defendants of the suit included the Secretary, all the nursing home owners and administrators of Medicaid certified nursing homes in Colorado, and the officers of the Colorado Department of Social Services and the Colorado Department of Health. *Id.* The only defendant that remained at the time of trial was the Secretary. *Id.* at 292. The State officials were dropped from the suit in exchange for their stipulation that the State would file a complaint against the Secretary seeking a revision of the Medicaid nursing home enforcement system. *Id.* at 291. Pursuant to the stipulation of dismissal, the Colorado Attorney General filed a suit against the Secretary seeking declaratory and injunctive relief for the Secretary's alleged failure to fulfill the mandate of the Social Security Act of 1935 by not effectively regulating Medicaid nursing homes. *Id.* at 290–91.

459. *Id.* at 293–94 (noting that, although the states administer the Medicaid program, the plaintiffs argued that the Secretary had a duty to regulate Colorado's Medicaid plan based on the powers Congress granted the Secretary under Medicaid).

460. *See id.* at 295 (discussing the issue of whether HHS's published forms were sufficient under the law).

461. HHS provided the states with Form SSA-1569 to certify the compliance of nursing home's with the Medicaid requirements. *Id.*

Medicaid recipients violated the "look behind" provision.[462] Agreeing with the Secretary, the court ruled that HHS had fulfilled the requirements of the Medicaid Act by promulgating regulations and providing forms to the states, reasoning that the duty to ensure that the residents of nursing homes received quality care was up to the Colorado Department of Health through its licensure powers.[463]

In 1984, the plaintiffs appealed the case to the United States Court of Appeals for the Tenth Circuit.[464] Reversing the district court's decision, the court ruled that the Secretary had violated the plaintiffs' statutory rights by failing to regulate the quality of nursing home care provided patients.[465] Because the purpose of the Medicaid Act was to provide high quality medical care to needy persons, the court reasoned that the Secretary must "promulgate regulations that allow the Secretary to remain informed, on a continuing basis, as to whether facilities receiving federal money are meeting the requirements of the Act" and to insure that the facilities are providing high quality patient care.[466] Providing this high quality care was an ongoing requirement; therefore, the Secretary has a duty of continued supervision of a nursing home rather than just initial knowledge of a nursing home's capability to provide high quality patient care.

The court further reviewed the legislative history of the "look behind" provision and found that even though the Medicaid Act requires each state to develop specific medical standards and actually conduct the certification and recertification nursing home inspections, the Medicaid Act does not absolve the Secretary of the overall responsibility that the states and their nursing homes comply.[467] The court based this decision on several duties in the Medicaid Act that were granted solely to the Secretary, not the states. First, the Secretary, not the states, actually determined whether facilities are approved for Medicaid participation.[468] Second, to receive federal funds states agreed to comply with federal statutory requirements of Medicaid.[469] Third, each state's inspection plan was approved or denied by the Secretary.[470] Fourth, the states utilized federal forms, procedures, and methods during their inspections.[471] Each of these steps required the Secretary to ensure that federal dollars were not being spent on mere

462. *In re* Estate of Smith v. Heckler, 747 F.2d 583, 588 (10th Cir. 1984). In fact, out of the 541 questions contained in the form, only thirty were related to patient care or required actual patient observation. *Id.*; *see also O'Halloran*, 557 F. Supp. at 295 (noting the plaintiffs' allegation that Form SSA-1569 was defective because it was "facility-oriented" instead of "patient-oriented").

463. *O'Halloran*, 557 F. Supp. at 296–97.

464. *Heckler*, 747 F.2d at 583, 585.

465. *Id.* at 590–91.

466. *Id.* at 590.

467. *Id.* at 589–90.

468. *Id.* at 589.

469. *Id.*

470. *Id.*

471. *Id.*

paper compliance by the states or an individual nursing home; rather, the key to the regulation was that the patients actually received quality care.[472]

Consequently, the court ruled that, by granting the Secretary the look-behind authority, Congress mandated the Secretary to make an independent determination of whether a Medicaid certified nursing home actually meets the requirements of Medicaid irrespective of the state's findings when the Secretary had cause.[473] Cause included complaints made to the Secretary by the residents, advocates, or others about the quality of care or condition of the facility.[474] Because the residents in *Heckler* had complained to the Secretary about the quality of care and the Secretary failed to use his authority under the "look behind" provision, the court remanded the case back to the district court and ordered the court to compel the Secretary to revise and implement new Medicaid regulations that focused on the quality of care furnished to Medicaid recipients in nursing homes.[475]

Applying the standard in *Heckler*, African Americans should prevail against the Secretary. African Americans are consistently denied reasonably prompt access to medically necessary nursing home services because nursing homes deny African Americans admission. This empirical data consistently demonstrates that for the last two decades elderly African Americans have been and remain subject to delays in transfer and denial of admission to quality nursing home care in spite of state nursing home plans. As in *Heckler*, the Secretary has cause to sanction the states because many Title VI complaints and research studies have noted states' failure to provide African Americans with reasonably prompt access to nursing home care. To date, the Secretary has not decreased Medicaid payments to states that fail to adequately discipline these nursing homes. Hence, the court should find that the Secretary has violated the "look behind" provision.

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472. *Id.* at 589–90.

473. *Id.* at 590; *see also* H.R. CONF. REP. NO. 96-1479, at 140–41 (1980) ("The conference agreement included . . . a modification limiting the Secretary's authority to 'look behind' a State's survey . . . to situations in which the Secretary has cause to question the adequacy of the State's determination.").

474. H.R. CONF. REP. NO. 96-1479, at 141.

475. *Heckler*, 747 F.2d at 591–92. On April 29, 1985, the United States District Court for the District of Colorado ordered the Secretary to promulgate new regulations consistent with the Court of Appeals mandate. *In re* Estate of Smith v. Heckler, 622 F. Supp. 403, 404 (D. Colo. 1985). Nevertheless, the Secretary failed to meet all the objectives of the order and was ordered to revise its regulations and finally found in contempt of the order in 1987. *In re* Estate of Smith v. Bowen, 656 F. Supp. 1093, 1099 (D. Colo. 1987). After repeated failures, the Secretary was finally found in contempt of the order in 1987. *In re* Estate of Smith v. Bowen, 675 F. Supp. 586, 590 (D. Colo. 1987). In 1988, the Secretary submitted the passage of the NHRA as means of compliance, but the court ruled that, "[t]he passage of the OBRA [of 1987] in no way modifies or preempts the Tenth Circuit's decision." Smith v. Bowen, 1988 WL 235574, at *1 (D. Colo. Frb. 18, 1988). In June, the Secretary finally enacted regulations in compliance with the court's order, amending both the Medicaid and Medicare regulations. Medicare and Medicaid; Long-Term Care Survey, 53 Fed. Reg. 22,850, 22,850–01 (June 17, 1988) (codified as amended at 42 C.F.R. pts. 405, 442, 488).

C. Merits of the NHRA Case

Under the NHRA, nursing homes are required to "care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident" and "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident . . . ."[476] The NHRA requires at 42 U.S.C. § 1396r(f)(1) and (g)(1)(A) that the states and Secretary ensure that nursing homes provide residents with quality care.[477]

Empirical data consistently demonstrates that for the last two decades elderly African Americans have been and remain subject to poor quality nursing home care in spite of state nursing home enforcement programs.[478] Discussed in detail in Part I.C, African Americans are more likely to suffer late-stage pressure sores and be hospitalized.[479] Furthermore, the facilities in which African Americans reside provide worse care than facilities in which Caucasians live.[480] African Americans reside in nursing homes "with lower ratings of cleanliness/maintenance and lighting . . . ."[481] Yet, the states have not increased the discipline of these nursing homes that provide substandard quality of care to African Americans, nor has the Secretary decreased Medicaid payments to states that fail to adequately discipline these nursing homes.[482] Thus, the Secretary and the states are in violation of the NHRA's requirements for nursing homes.

One weakness of the claims based on the NHRA's requirements for nursing homes is that the Secretary and the states actively regulate the quality of care of nursing home residents. The state and Secretary may cite the current survey and certification system and argue that the state's plan and Secretary's review of the states' plan is sufficient to provide quality care to Medicaid residents, fulfilling their duty to nursing home residents. Moreover, the Secretary and the states may submit that, although African Americans do not receive quality care, most Medicaid patients residing in nursing homes receive quality care, which is all that is required by the NHRA. The empirical evidence, however, does not support this contention.

Instead, empirical research shows that nursing homes that primarily rely on Medicaid provide poor quality of care compared to nursing homes that primarily rely on private pay payments.[483] The quality of care provided by some nursing

476. 42 U.S.C. § 1396r(b)(1)(A), (2) (2006).

477. *Id.* §1396r(f)(1), (g)(1)(A).

478. *See supra* Part I.

479. Spinner, *supra* note 123.

480. *See* Mor et al., *supra* note 25, at 240 (discussing racial disparities in nursing home care).

481. Grabowski, *supra* note 92, at 456.

482. Yearby, *supra* note 8, at 486; *see supra* Part II.B.1–2.

483. Mor et al., *supra* note 25, at 227–28.

homes whose primary source of payment is Medicaid is so poor that researchers deemed these nursing homes as *lower-tiered facilities*.[484] It is crucial to note that, though African Americans and Caucasians reside in poor quality Medicaid nursing homes,[485] African Americans are three to five times more likely to be in lower-tiered facilities than Caucasians.[486] These lower-tiered facilities have significant Medicaid deficiencies, such as using physical restraints unnecessarily, and having inadequate pain control and inappropriate use of antipsychotic medications,[487] which are not being rectified by the current regulations.[488] Contrary to the Secretary and the states' arguments, the current Medicaid nursing home enforcement system is not up to the task of providing quality nursing home care, which disproportionately affect African American residents.

Whether African Americans are successful on the merits depends on whether courts are willing to eradicate the meaningless distinctions in reasonable promptness between providing financing and providing services, and the difference under the NHRA between right to services and right to *quality* services. The fact that the Secretary and the states finance nursing home stays for Medicaid patients is inconsequential if African Americans are consistently delayed transfer and denied admission to quality nursing homes. Four decades after the enactment of Title VI, the time has come to provide African Americans with reasonably prompt access to quality nursing home care.

CONCLUSION

Minority patients are overrepresented in poorer quality nursing homes and "[r]ecent research suggests 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 [Caucasian] patients."[489] These racial inequities persist in spite of the civil rights laws that require health care entities to provide equal access to health care, regardless of race.[490] Traditionally, individual African Americans have used Title VI to try to rectify racial inequities, but these

484. *Id.* at 227.

485. *See* Grabowski, *supra* note 92, at 460 (reviewing race and socioeconomic status, and finding that Medicaid and Medicare patients were admitted to poor quality facilities).

486. Mor et al., *supra* note 25, at 238 & fig.2. This ratio varies by state from zero to nine, and the only state where the ratio is zero is Kentucky. *Id.* at 238 fig.2.

487. Cynthia Faye Barnett, *Treatment Rights of Mentally Ill Nursing Home Residents*, 126 U. PA. L. REV. 578, 596–97 (1978); Yearby, *supra* note 8, at 461–62.

488. *See* Mor et al., *supra* note 25, at 246 (noting that current regulations inadvertently perpetuate lower-tier facilities' deficiencies in meeting patient needs).

489. Mary L. Fennell, Editorial, *Racial Disparities in Care: Looking Beyond the Clinical Encounter*, 40 HEALTH SERVICES RES. 1713, 1717 (2005), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361239/.

490. Yearby, *supra* note 8, at 445–46; *see supra* note 9.

actions have failed to address racial discrimination because the government has not adequately sanctioned perpetrators of racial discrimination.[491]

In 1980, the Chairperson of the U.S. Commission on Civil Rights, Mary Frances Berry, noted that there was no absence of civil rights laws, merely an absence of civil rights enforcement by the government.[492] She suggested that the civil rights community could fix the problem by suing the government and inducing it to enforce Title VI in health care.[493] Twenty-nine years later, the time has come to put this suggestion into practice on a national level and take one step further. One such strategy is to use the civil rights laws to induce HHS and the states to fulfill their non-race-based regulatory duties as a way to re-invigorate civil rights enforcement.[494] This strategy is not just about forcing HHS and the states to fulfill their regulatory mandates. It is also about transforming a broken civil rights system that implicitly accepts the unequal treatment of elderly African Americans into an effective system that enforces proscriptions against racial discrimination, particularly in the nursing home industry.

491. *See supra* notes 51–52.

492. Ivie, *supra* note 48, at 35.

493. *Id.*

494. *See supra* Part III.