

## ARTICLES

### **Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of *Alexander v. Sandoval***

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On occasion, a decision by the United States Supreme Court in the area of federal civil rights law invites a profound rethinking of rights, remedies, and enforcement under federal law. Faced with such an invitation, the federal authorities charged with civil rights enforcement have often risen to the challenge and responded vigorously. For example, in 1999, the Supreme Court held in *Olmstead v. L.C.* that the medically unjustifiable institutionalization of persons with disabilities under publicly administered programs constitutes discrimination under the Americans with Disabilities Act.<sup>1</sup> The Court ordered that steps be taken toward

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1. 527 U.S. 581 (1999).

community integration “at a reasonable pace.”<sup>2</sup> Within days of the decision, the Secretary of the Department of Health and Human Services (HHS) acknowledged the importance of the case in an unprecedented letter to the nation’s governors;<sup>3</sup> within months, federal involvement by the Clinton Administration had dramatically expanded.<sup>4</sup> The Secretary instructed both the HHS Office for Civil Rights (OCR) and the Centers for Medicare and Medicaid Services (CMS; then the Health Care Financing Administration) to pursue active implementation strategies, which would include the issuance of interpretive guidelines, technical assistance to aid state compliance, expanded training of federal agency staff, and an aggressive program of internal assessment to determine the extent to which existing federal policies impeded community integration.<sup>5</sup> The incoming Bush Administration continued this national focus on disability rights through executive orders,<sup>6</sup> assessments of the performance of federal programs, and new initiatives to promote community integration.<sup>7</sup>

If the executive branch’s follow-up to *Olmstead* stands out as a model of responsiveness, its reaction to the recent Supreme Court ruling in

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2. *Id.* at 605–06. See also Sara Rosenbaum, *The Olmstead Decision: Implications for State Health Policy*, HEALTH AFF., Sept./Oct. 2000, at 228. We note that *Olmstead*’s implications for private conduct relating to the provision of employer-sponsored health and disability benefits are under review by various federal courts. See, e.g., *Johnson v. K-Mart Corp.*, No. 99-14563, 2001 U.S. App. LEXIS 24923 (11th Cir. Dec. 19, 2001), *reh’g granted*, 273 F.3d 1035 (11th Cir. 2001).

3. Letter from Timothy M. Westmoreland, Director, Center for Medicaid and State Operations, Health Care Financing Administration, & Thomas Perez, Director, Office for Civil Rights, to State Medicaid Directors (Jan. 14, 2000), available at <http://www.hhs.gov/ocr/olms0114.htm> (last visited May 29, 2002).

4. From the time it was handed down, *Olmstead* was understood to be of great moment in the administration of public programs, as evidenced by the highly publicized reaction of federal and state officials. See, e.g., Donna E. Shalala, Health Care Challenges for the New Millennium, Address at the National Conference of State Legislators (Jul. 28, 1999), available at <http://www.hhs.gov/ocr/olmstead.htm> (last visited May 29, 2002) (encouraging state legislators to invest the “time, effort, creativity and commitment” required to implement the *Olmstead* decision).

5. Kathleen A. Maloy, Alexandra Stewart & Sara Rosenbaum, *Beyond Olmstead v. L.C.: An Assessment of HHS/OCR’s Efforts to Implement a Community Integration Goal* (May 2002) (unpublished manuscript, on file with the authors) (prepared for the HHS Office for Civil Rights).

6. See, e.g., Exec. Order No. 13217, 66 Fed. Reg. 33,155 (June 19, 2001), available at <http://www.whitehouse.gov/news/releases/2001/06/20010619.html> (last visited May 29, 2002).

7. *Id.*

*Alexander v. Sandoval*<sup>8</sup> is just the opposite—a model of inaction and neglect. No case in recent memory has more urgently demanded the attention of the officials charged with the administration of civil rights laws in the context of federally funded programs. In *Sandoval*, a 5-4 majority held that individuals who allege disparate impact (*de facto*) discrimination under Title VI of the Civil Rights Act of 1964 (the Act),<sup>9</sup> which outlaws discrimination by programs receiving federal financial assistance, have no private cause of action to enforce their rights.<sup>10</sup> Although *Sandoval* left federal agencies with the exclusive province to enforce prohibitions against disparate-impact discrimination under Title VI, the response from HHS—the key enforcement agency for federally assisted health and human services programs—was virtual silence.<sup>11</sup> A search of news articles reporting on the decision failed to turn up a single statement from civil rights officials regarding the expanded importance of federal oversight obligations in the wake of *Sandoval*.<sup>12</sup> Similarly, the Bush Administration's

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8. 532 U.S. 275 (2001).

9. 42 U.S.C. § 2000a. Title VI, 42 U.S.C. § 2000d, prohibits discrimination on the basis of race, color, or national origin by programs and activities that receive federal financial assistance (“No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.”).

10. 532 U.S. at 293.

11. One noteworthy example of this silence is the Department of Justice's revision of policy guidance—since the time *Sandoval* was handed down—concerning the prohibition against national origin discrimination affecting persons with limited English proficiency (LEP). See Notice of Republication, Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency, 67 Fed. Reg. 4968 (Feb. 1, 2002). The revised guidance is notable for its utter lack of discussion in Section VIII of *Sandoval*'s implications for the Department's civil rights enforcement responsibilities. Moreover, the Department elsewhere asserts that compliance with its anti-discrimination directive is purely voluntary. See Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 67 Fed. Reg. 19,237 (Apr. 18, 2002), available at <http://www.usdoj.gov/crt/cor/lep/DOJLEPGuidApr122002.htm> (last visited May 29, 2002) (noting that “[t]he goal for Title VI and Title VI regulatory enforcement is to achieve voluntary compliance”).

12. According to a search of Lexis-Nexis databases, in the first three months following the decisions, eighteen major newspapers ran *Olmstead* articles, while twenty ran *Sandoval* stories. Of all news outlets, eighty-two articles discussed the *Olmstead* decision, compared with eighty-five *Sandoval* stories. Nine months after each of the two rulings, again analyzing all news outlets, 137 articles covered *Olmstead*, while 117 discussed *Sandoval*. Putting aside the apparent similar newsworthiness of the two decisions, it is worth noting that there has

Fiscal Year 2003 budget request for civil rights enforcement in health care (the first presidential budget proposal following the *Sandoval* decision) contains no suggestion of the increased importance of federal civil rights enforcement activities following the decision.<sup>13</sup>

The failure of the federal government to respond vigorously to the *Sandoval* decision, as it vigorously responded to *Olmstead*, threatens to deepen a crisis of confidence regarding the willingness of society at large to decisively address one of the most fundamental problems in United States health policy—that of racial and ethnic discrimination.<sup>14</sup> The federal government's failure to respond to *Sandoval* grew more striking following the Spring 2002 release of the Institute of Medicine's (IOM) landmark study *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.<sup>15</sup> That study documented the pervasive nature of "racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences and appropriateness of intervention."<sup>16</sup> The IOM study goes to the heart of the problem, namely the widespread and systemic discriminatory conduct within the United States health care system that begins at the point of entry and continues throughout the secondary and tertiary pathways of the system.<sup>17</sup> It is precisely this sort of systemic problem that Title VI was enacted to prevent.

This Article examines the *Sandoval* decision and its implications for federal civil rights enforcement activities in the modern health care system. Part I presents an overview of Title VI, examining the rights and obligations it creates as well as its federal enforcement and oversight

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been no suggestion we could find that the contrasting executive branch responses to *Sandoval* and *Olmstead* stemmed from the fact that somehow the net effect of the two cases in a health care context is different; both involve discrimination against a protected sub-population for reasons wholly unrelated to the appropriateness of care.

13. Indeed, HHS/OCR's budget request sought an overall increase that roughly approximated a nominal increase for inflation. See Office for Civil Rights, *FY2003 Budget*, available at <http://www.hhs.gov/ocr/fy03budget.html> (last visited May 29, 2002).

14. See discussion *infra* Part II.

15. INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* (Brian D. Smedley et al. eds., 2002) [hereinafter *UNEQUAL TREATMENT*].

16. *Id.* at 4.

17. For evidence corroborating the IOM findings, see, for example, HENRY J. KAISER FAMILY FOUND., *KEY FACTS: RACE, ETHNICITY AND MEDICAL CARE* (1999); MOREHOUSE MED. TREATMENT EFFECTIVENESS CTR., *A SYNTHESIS OF THE LITERATURE: RACIAL AND ETHNIC DIFFERENCES IN ACCESS TO MEDICAL CARE* (Robert M. Mayberry et al. eds., 1999); Kathryn A. Phillips et al., *Barriers to Care Among Racial/Ethnic Groups Under Managed Care*, *HEALTH AFF.*, July/Aug. 2000, at 65.

structure. We also briefly review the history of private litigation attempting to enforce Title VI in a health care context. Part II examines the existing federal administrative system for enforcing Title VI and reviews evidence regarding the HHS Office for Civil Rights's ability to enforce anti-discrimination law. In Part III, we discuss *Sandoval* and examine the Supreme Court's reasoning in departing from longstanding principles of civil rights jurisprudence.

Finally, we argue in Part IV that regardless of whether Congress reverses *Sandoval* through legislation, there is an enormous need for a fundamental restructuring of federal civil rights oversight activities. With federal spending dominating a health system that is growing ever more complex, there is a compelling need to unequivocally grant civil rights enforcement responsibilities to the federal agencies with the power to make expenditure decisions. These agencies should not only investigate and sanction, but also set the standards for the entities that they oversee. This structural change is particularly important given that these agencies control the distribution of hundreds of billions of dollars to public and private entities ranging from state and local government agencies to the nation's leading teaching hospitals, research and training programs, and health care corporations.

## I. AN OVERVIEW OF TITLE VI AND ITS ENFORCEMENT

The Civil Rights Act of 1964,<sup>18</sup> of which Title VI is a part, was a critical development in the evolution of American social policy. The Act created a broad remedial structure to end discrimination in employment, places of public accommodation, and programs and activities (including health care providers and programs) that receive federal financial assistance.<sup>19</sup> Because it derives from Congress' powers under the Spending Clause of the Constitution,<sup>20</sup> Title VI does not reach purely private conduct, such as the

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18. Pub. L. No. 88-352, 78 Stat. 253 (codified as amended at 42 U.S.C. § 2000a (1994)).

19. Nearly thirty years after passage of the 1964 Act, the Americans with Disabilities Act of 1990 would classify private health care providers as places of public accommodation, a step that signaled a profound evolution in societal expectations of the health system and its basic accountability. *See* Americans with Disabilities Act, 42 U.S.C. § 12182 (1990); *Bragdon v. Abbott*, 524 U.S. 624 (1998).

20. U.S. CONST. art. I, § 8, cl. 1. We note parenthetically that Spending Clause legislation, including Title VI, is critical to the preservation and protection of civil rights given the current Supreme Court's inclination to strike down on federalism grounds congressional pronouncements based on the Commerce Clause. *See, e.g., U.S. v. Morrison*, 529 U.S. 598 (2000); *U.S. v. Lopez*, 514 U.S. 549 (1995). Indeed, "[t]he Spending Clause is

activities of health professionals who do not directly participate in government insurance programs.<sup>21</sup> But the reach of federal funding in the U.S. health care system is so enormous that very little of the modern health care enterprise lies beyond the scope of Title VI.<sup>22</sup>

The legislative history of Title VI indicates that health care was prominent in the minds of its authors. The history also reveals that all forms of discrimination in health care—both deliberate acts of discrimination and conduct that unintentionally results in harm to racial minorities—were a driving force behind the law's enactment.<sup>23</sup>

Moreover, passage of the 1964 Act was contemporaneous with the judicial ruling in *Simphkins v. Moses H. Cone Memorial Hospital*,<sup>24</sup> which found unconstitutional a key portion of the Hospital Survey and Construction Act of 1946 (known as the Hill-Burton Act),<sup>25</sup> which had authorized the use of federal funds to construct and operate segregated health care facilities.<sup>26</sup> With the enactment of Medicare and Medicaid the following year, the federal government's power to use federal financial participation to force an end to discriminatory treatment was seemingly limitless.<sup>27</sup>

In this Part, we first review key terms under Title VI with an emphasis

perhaps the clearest method of avoiding constitutional challenges to congressional acts under the Commerce Clause or Tenth Amendment." Julian Epstein, *Evolving Spheres of Federalism After U.S. v. Lopez and Other Cases*, 34 HARV. J. ON LEGIS. 525, 553 (1997) (footnotes omitted). It is for this reason that scholars have advocated that Congress use its spending power to expand the scope of its civil rights enforcement power. See, e.g., Daniel O. Conkle, *Congressional Alternatives in the Wake of City of Boerne v. Flores: The (Limited) Role of Congress in Protecting Religious Freedom from State and Local Infringement*, 20 U. Ark. Little Rock L.J. 633, 668 (1998).

21. See Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn't Be So Easy*, 58 FORDHAM L. REV. 939, 944 (1990).

22. Thomas E. Perez, *The Civil Rights Dimensions of Racial and Ethnic Disparities in Health Care*, in UNEQUAL TREATMENT, *supra* note 15, at 362–90.

23. CIVIL RIGHTS DIV., U.S. DEP'T OF JUSTICE, TITLE VI LEGAL MANUAL (2001), available at <http://www.usdoj.gov/crt/cor/coord/vimannual.htm> (last visited July 5, 2003); DAVID BARTON SMITH, *HEALTH CARE DIVIDED: RACE AND HEALING A NATION* (1999).

24. *Simphkins v. Moses H. Cone Mem'l Hosp.*, 323 F.2d 959 (4th Cir. 1963).

25. Pub. L. No. 88-443, § 3(a), 78 Stat. 447 (codified as amended at 42 U.S.C. §§ 291. (2003)).

26. SMITH, *supra* note 23, at 101–03.

27. Indeed, as David Barton Smith, *supra* note 23, recounts in his exceptional book detailing the history of this country's racially divided health care system, so powerful was the nexus between Title VI and Medicare that the existence of Title VI threatened Medicare's passage because of opposition by some Southern senators to such a huge expansion of civil rights authority into the health system. *Id.*

on their application to health care. We then describe the mechanisms for public enforcement of Title VI. Finally, we examine private enforcement under Title VI.

### A. Key Terms in Title VI

The provisions of Title VI prohibit discrimination on the basis of race, color, or national origin by programs and activities that receive federal financial assistance. Section 601 of the Act provides that “[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.”<sup>28</sup> Section 602 “authorize[s] and direct[s]” federal agencies to “effectuate the provisions of section 601” by promulgating and enforcing “rules, regulations, or orders of general applicability.”<sup>29</sup> The law thus imposes on federal agencies a duty to act, not merely the discretion to do so. As a result, federal regulations set forth an administrative enforcement mechanism that authorizes federal agencies to set non-discrimination standards, investigate claims of discrimination, and terminate federal assistance to any entity that is found to have violated the law.<sup>30</sup>

The term “discrimination” is not defined in Title VI; under the statute, each federal agency that oversees programs of federal financial assistance must promulgate regulatory standards—which would include a definition of discrimination—to enforce the law. Early efforts to produce a common set of standards regarding discrimination across all federal agencies offering federal financial assistance led to a series of twenty-two sets of rules that stemmed from a model initially developed for the U.S. Department of Health, Education and Welfare (the predecessor agency to HHS).<sup>31</sup> The rules, which remain in force and virtually unchanged, extend beyond acts of intentional discrimination and reach conduct and practices that, even if facially neutral, have a disproportionate adverse impact on members of minority groups. In the case of health and human services, federal regulations use in part the following broad language to identify prohibited activities:

A recipient, in determining the types of services, financial aid, or other

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28. Pub. L. No. 88-352, § 601, 78 Stat. 252 (codified at 42 U.S.C. § 2000d (2003)).

29. 42 U.S.C. § 2000d-1.

30. 28 C.F.R. §§ 42.101–412 (2001); *see also* Guidelines for the Enforcement of Title VI, 28 C.F.R. § 50.3 (2001).

31. Watson, *supra* note 21, at 947-48.

benefits, or facilities which will be provided under any such program, or the class of individuals to whom, or the situations in which, such services, financial aid, other benefits, or facilities will be provided under any such program, or the class of individuals to be afforded an opportunity to participate in any such program, may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which *have the effect* of subjecting individuals to discrimination because of their race, color, or national origin, *or have the effect* of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin.<sup>32</sup>

These standards were designed to target relevant conduct while still being sufficiently flexible to retain their force over time.<sup>33</sup> For example, in their prohibition of discrimination either directly or through contractual arrangements, the regulations would appear to apply not only to traditional health care entities such as hospitals, nursing homes, and other "brick and mortar" institutions,<sup>34</sup> but also to modern managed care entities that function as insuring intermediaries with contractually networked providers.<sup>35</sup> Despite the vast changes in the U.S. health system that have occurred since the promulgation of these regulations, it is evident that they retain sufficient vigor to reach all types of federally assisted agencies and entities operating directly or by contract, regardless of whether they are housed in single facilities or scattered across a community through far-flung service networks.

Because the American health care system is overwhelmingly privately owned and operated, it is essential in a discussion of Title VI to understand the meaning of the terms "federal financial assistance," "recipient," and "program or activity." The Department of Justice explains that "federal financial assistance includes more than money" and may include such benefits as the use of federal land and the lending of federal personnel.<sup>36</sup> Federal financial assistance does not include contracts of guarantee or insurance, or direct payments to individuals, but the term does include contracts that have as a purpose the provision of federal financial assistance.<sup>37</sup> For example, a contract between a state Medicaid program and

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32. 45 C.F.R. § 80.3(b)(2) (2001) (emphasis added).

33. Watson, *supra* note 21, at 947.

34. See, e.g., NAACP v. Wilmington Med. Cir., Inc., 491 F. Supp. 290 (D. Del. 1980).

35. See RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 584 (1997).

36. CIVIL RIGHTS DIV., *supra* note 23, at 16-20.

37. *Id.*



a managed care organization to serve Medicaid beneficiaries may be covered by Title VI.<sup>38</sup> Other examples include federal payments to Medicare+Choice managed care organizations, payments to health professions teaching programs, and federal research grants.

Beyond the breadth of the term “federal financial assistance,” the reach of Title VI is further expanded because of the related concepts of “recipient” and “program or activity.” The Justice Department notes that under federal rules a “recipient” can be “any State, political subdivision of any State, or instrumentality of any State or political subdivision.”<sup>39</sup> The term “recipient” also covers “any public or private agency, institution, or organization, or other entity . . . to whom federal financial assistance is extended. . . .”<sup>40</sup> The concept of “program or activity” has been interpreted broadly as well so that it subjects an entire entity to Title VI, not merely the portion that receives federal financial assistance.<sup>41</sup> Thus, for example, federal student loan payments to a university are sufficient to establish a nexus between Title VI and all university operations, not merely those activities specifically undertaken with, or in furtherance of, the student loan program. In other words, the presence of federal program beneficiaries within a larger enterprise that also serves private-pay individuals is sufficient to subject the entire enterprise to federal anti-discrimination law. The underlying theory of this interpretation of the law, reinforced by Congress in the Civil Rights Restoration Act of 1987,<sup>42</sup> is that when federal funds flow to a large enterprise, the funds help support the entire enterprise, not merely a specific element.

It was not an accident in the history of Title VI that Medicare payments to private physicians are not considered as federal financial participation. In his excellent history of Title VI and its enforcement in a health care context, David Barton Smith notes that, in the face of Southern opposition to the application of Title VI to Medicare, the Johnson Administration, in order to secure Medicare’s enactment, effectively promised to exempt physicians from Title VI enforcement actions by classifying Medicare Part B payments as direct assistance to individuals, rather than as federal financial

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38. Office for Civil Rights, U.S. Dep’t of Health and Human Svcs., *Fact Sheet, Your Rights Under Title VI of the Civil Rights Act of 1964*, available at <http://www.dhhs.gov/ocr/title6.html> (last visited May 29, 2002) (noting that Medicare and Medicaid may be programs covered by Title VI).

39. 28 C.F.R. § 42.102(f) (2001); CIVIL RIGHTS DIV., *supra* note 23, at 20.

40. 28 C.F.R. § 42.102(f) (2001).

41. CIVIL RIGHTS DIV., *supra* note 23, at 25.

42. Pub. L. No. 100-259, 102 Stat. 28 (1988) (codified as amended at 20 U.S.C. §§ 1681-88 (1994)).

assistance to physicians.<sup>43</sup> This promise effectively eliminated a principal basis of Title VI jurisdiction over the conduct of private physicians. The logic of this position flowed from Medicare's original structure as, by and large, an indemnifier of individual patients for payments made to private physicians for covered services. Medicare's evolution has, of course, eclipsed this original model; today, physicians overwhelmingly receive Medicare payments directly, and in its 2000 Limited English Proficiency guidelines, OCR classified Medicare payments as a form of federal financial assistance, suggesting an end to this longstanding policy of exemption for physicians.<sup>44</sup>

### *B. Public Enforcement of Title VI*

Given the broad scope of Title VI, administrative agencies have developed mechanisms to enforce compliance with Title VI's terms. In this Section, we describe these mechanisms. In Part II, we embark upon a more focused look at the enforcement mechanisms specific to the health care context in an effort to expose their deficiencies.

An individual who chooses to use Title VI's administrative enforcement machinery begins the process by filing an administrative complaint with the appropriate federal agency.<sup>45</sup> Where federal health programs are at issue, this agency is the HHS Office for Civil Rights (OCR), which, under the organizational rules of the Department, is granted authority to investigate violations of civil rights law. Federal rules provide that an agency "will make a prompt investigation whenever a . . . complaint . . . indicates a possible failure to comply with [Title VI requirements]."<sup>46</sup> If an official investigation indicates a failure to comply, "the responsible Department official . . . will so inform the recipient and the matter will be resolved by informal means whenever possible."<sup>47</sup> If the agency determines that the matter cannot be resolved informally, then judicial action "will be taken."<sup>48</sup> On the other hand, if the official investigation concludes that no action is warranted, the agency must inform the complainant and recipient of this result.<sup>49</sup>

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43. SMITH, *supra* note 23, at 115–28.

44. Policy Guidance on the Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency, 65 Fed. Reg. 52,762 (Aug. 30, 2000).

45. 28 C.F.R. § 42.107(b) (2001).

46. *Id.* § 42.107(c).

47. *Id.* § 42.107(d)(1).

48. *Id.*

49. *Id.* § 42.107(d)(2).

The power assigned to federal agencies under Title VI extends beyond the task of investigating individual complaints. Under the express terms of Section 602, this power includes the authority (if not a legally enforceable public duty)<sup>50</sup> to set rules of general applicability that provide recipients of federal financial assistance with standards for achieving compliance under the law. Under both the Act and normal principles of administrative law, federal agencies have the discretion to promulgate generally applicable rules of conduct that define the obligations and duties of recipients of federal financial assistance. To bolster their enforcement power, federal agencies require that all recipients of federal financial assistance file assurances of compliance with the terms of Title VI.<sup>51</sup>

Title VI administrative enforcement procedures thus vest federal agencies with considerable discretion to design, implement, and evaluate civil rights enforcement standards and procedures, with duties ranging from issuing policies to investigating specific incidents.<sup>52</sup>

### C. Private Enforcement of Title VI

Like much of the legislation of its time, Title VI was silent on the issue of whether private individuals who had suffered discrimination by covered entities could bring lawsuits to enforce their rights under the law. However, until the *Sandoval* decision, many federal courts had inferred a private right of action under the law to enforce the legal protections contained in both the statute itself and its implementing regulations.<sup>53</sup> The

50. Of course, whether individual claimants could actually enforce this duty is another matter. For example, in *Madison-Hughes v. Shalala*, 80 F.3d 1121 (6th Cir. 1996), plaintiffs were unsuccessful in a suit against the federal government in which they sought to compel the government to include queries as to the race and ethnic identity of patients on a standard billing form used by health care institutions seeking reimbursement from federally sponsored health programs.

51. 28 C.F.R. § 42.105(a) (2001).

52. The United States Commission on Civil Rights has extensively described the scope of this discretion in its 1999 study of discrimination in health care. 2 U.S. COMM'N ON CIVIL RIGHTS, *THE HEALTH CARE CHALLENGE: ACKNOWLEDGING DISPARITY, CONFRONTING DISCRIMINATION, AND ENSURING EQUALITY* 17–49 (1999). The report is discussed *infra* Part II.

53. Indeed, every federal Court of Appeals to address the question prior to *Sandoval* concluded that a private right of action exists to enforce the rights guaranteed both by the text of Title VI and by any regulations validly promulgated pursuant to that Title. *See, e.g.*, *Powell v. Ridge*, 189 F.3d 387, 400 (3d Cir. 1999); *Ferguson v. Charleston*, 186 F.3d 469 (4th Cir. 1999), *rev'd on other grounds*, 532 U.S. 67 (2001); *Sandoval v. Hagan*, 197 F.3d 484 (11th Cir. 1999); *Chester Residents Concerned for Quality Living v. Seif*, 132 F.3d 925, 936–37 (3d Cir. 1997), *vacated*, 524 U.S. 974 (1998); *Buchanan v. Bolivar*, 99 F.3d 1352, 1356 n.5

distinction between protections found in the statute and those created by regulations is important because the two reach distinct types of conduct. The statute prohibits disparate treatment, which encompasses claims of intentional discrimination. A disparate treatment claim requires proof of motive, which can be inferred from circumstances surrounding the defendant's conduct (for example, requiring all African-American or Latino patients to prepay certain tests or procedures that otherwise are furnished to patients on a "bill later" basis).

The second type of conduct, prohibited by the regulations implementing Title VI and termed "disproportionate adverse impact" discrimination, is the sort at issue in the *Sandoval* case. It focuses on conduct that is facially neutral but falls more heavily on members of minority groups and cannot be justified by the defendant.<sup>54</sup> Claims of this type involve allegations that a recipient of federal financial assistance, "in violation of federal regulations," has used a "neutral procedure or practice" that has a "disparate impact on protected individuals, and such practice lack[ed] a substantial legitimate justification."<sup>55</sup> In a disparate impact case, the focus is thus on the *consequences* of the conduct, rather than the recipient's intent.

As with other laws that proscribe certain conduct, Title VI enforcement turns on the basic elements of the claim, the permissible defenses, and the allocation of the burden of proof between the parties. Because Title VI and its regulations outlaw both intentional discrimination and facially neutral conduct having a disproportionate adverse impact, the defenses and burdens of enforcement depend on the nature of the claim.<sup>56</sup> Title VI health care cases have never been particularly common, nor particularly successful. Numerous reviews of the use of Title VI in health care discrimination cases have offered the same explanation: the manner in which burdens are allocated under Title VI litigation and the difficulty

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(6th Cir. 1996); *Villanueva v. Carere*, 85 F.3d 481, 486 (10th Cir. 1996); *New York Urban League, Inc. v. New York*, 71 F.3d 1031, 1036 (2d Cir. 1995); *David K. v. Lane*, 839 F.2d 1265, 1274 (7th Cir. 1988); *Latinos Unidos De Chelsea v. Sec'y of Hous. & Urban Dev.*, 799 F.2d 774, 785 n.20 (1st Cir. 1986); *Castaneda v. Pickard*, 781 F.2d 456, 465 n.11 (5th Cir. 1986); *Larry P. v. Riles*, 793 F.2d 969, 981-82 (9th Cir. 1986).

54. *Watson*, *supra* note 21, at 948-49; CIVIL RIGHTS DIV., *supra* note 23, at 34.

55. CIVIL RIGHTS DIV., *supra* note 23, at 34.

56. See generally Daniel Hampton, *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 (1996); Sara Rosenbaum et al., *U.S. Civil Rights Policy and Access to Health Care by Minority Americans: Implications for a Changing Health Care System*, 57 MED. CARE RES. & REV. 236 (2000).

plaintiffs face in meeting the burdens.<sup>57</sup>

In disparate treatment claims (i.e., claims of intentional discrimination), “smoking gun” evidence of discriminatory motive is rare, so plaintiffs typically rely on circumstantial evidence. Disparate treatment cases often involve a “three-step proof model” that focuses on “circumstantial evidence in an effort to uncover the defendant’s true motive.”<sup>58</sup> The three steps are the plaintiff’s presentation of *prima facie* evidence that discrimination exists, the defendant’s rebuttal of the evidence based on any legitimate reason for its existence, and finally the plaintiff’s attempt to prove that the defendant’s proffered basis is but a pretext cloaking a discriminatory motive. As with other state-of-mind offenses, proving motive (and therefore prevailing as a plaintiff) is extremely difficult.

In disproportionate adverse impact cases, the impact of the conduct and not the motive is at issue, and the goal is to identify and remove barriers that unnecessarily produce disproportionate adverse results for a protected minority group.<sup>59</sup> Again, there is a three-step test. The first step resembles that in a disproportionate treatment claim: A plaintiff makes out a *prima facie* case through statistical evidence that a facially neutral barrier has a disproportionate impact on a protected group. In health care, examples of these barriers include a defendant hospital’s decision to place a limit on its number of Medicaid beds,<sup>60</sup> to relocate its facilities to a wealthier neighborhood,<sup>61</sup> or to refuse to participate in the Medicaid program altogether.<sup>62</sup> The defendant then has the burden of justifying the alleged discriminatory practice by arguing that it serves a legitimate goal. For example, in a non-participation case, a defendant might show that Medicaid rates are so low in relation to the cost and financial risks of patient care that participation would generate significant financial losses for the institution. In a relocation case, the defendant might show that a

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57. See, e.g., Hampton, *supra* note 56; Rosenbaum et al., *supra* note 56; Watson, *supra* note 21.

58. Watson, *supra* note 21, at 956.

59. Watson, *supra* note 21. In a health care context, examples of such barriers include using patient co-payments as a condition of receiving treatment, or designing physician office hours based on patient insurance status (e.g., by only permitting Medicaid beneficiaries access to a physician’s office on particular days of the week or during particular times during the day).

60. See, e.g., Linton v. Carney, 779 F. Supp. 925 (M.D. Tenn. 1990).

61. See, e.g., Bryan v. Koch, 627 F.2d 612 (2d Cir. 1980); Wilmington Gen. Hosp. v. Manlove, 174 A.2d 135 (Del. 1961).

62. See, e.g., Cook v. Ochsner Found. Hosp., 319 F. Supp. 603 (E.D. La. 1970).

move was necessary as a response to a basic shift in the institution's essential economic base. Similarly, a decision to close clinics in a poor neighborhood as part of a move might be defended as necessary to improve revenues and achieve greater operational efficiency.<sup>63</sup>

If the defendant makes the requisite showing of legitimate purpose, the plaintiff may rebut this defense by demonstrating a plausible alternative policy with less adverse disparate impact. While demonstrating the feasibility of a less adverse alternative is not as difficult as proving motive and pretext in a disparate treatment case, the burden on the plaintiff remains very steep. Since plaintiffs lack the business and marketing knowledge relevant to assessing defendants' choices, placing the burden of ascertaining the range of options on the plaintiff creates an enormous obstacle. This is particularly true in the case of private health care enterprises, where the responsibility to show the existence of realistic business alternatives requires a highly sophisticated analysis of business practices and access to huge amounts of data specific to the defendant's business.

To allow a recipient of federal assistance to defend *de facto* discriminatory practices as simply furthering a "legitimate" business goal (for example, the all-purpose legitimate goal of making an acceptable return on investment) means that plaintiffs are effectively placed in the position of having to contest the basic assumptions of the enterprise itself. In the absence of federal standards that describe a range of legitimate approaches and require conformity as a condition of federal funding, the courts have in effect assigned to private plaintiffs the task of second-guessing business decisions even though they lack access to the evidence needed to complete this task.<sup>64</sup>

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63. See, e.g., *Bryan v. Koch*, 627 F.2d 612 (2d Cir. 1980); *Cook v. Ochsner Found. Hosp.*, 319 F. Supp. 603 (E.D. La. 1970).

64. There is one example of an enforcement approach that involves the setting of prospective standards identifying the range of legitimate responses by federal recipients to their federal duties under Title VI. In 2000, the Health and Human Services Office for Civil Rights issued limited English proficiency guidelines that provided relatively detailed instructions to recipients of federal financial assistance (including agencies and health institutions) regarding approaches to compliance. *Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services; Effectuation of Title VI of the Civil Rights Act of 1964*, 45 C.F.R. pt. 80 (2000). The guidelines were immediately and aggressively challenged by a broad coalition of provider organizations and associations, but have remained in effect nonetheless. In its effort to both identify a major activity (i.e., the availability of services in a language other than English) on the part of federal financial assistance recipients and describe the range of responses to this

Plaintiffs in the few Title VI health care cases that have been litigated over the years have tended not to fare well.<sup>65</sup> In cases in which a plaintiff has been able to prove discriminatory impact on the basis of practices aimed at minority and non-minority patients receiving health care in the same geographic market, there have been victories. Thus, for example, separating hospital beds on the basis of insurance status or program in the same facility, or limiting the number of Medicaid beds in a single nursing facility, might amount to a successful case, since within the same service area there is an identifiable practice (i.e., separating patients by payer source) that has a disproportionate adverse impact on protected individuals. Yet even here it might be possible for a defendant to show a legitimate business reason for the practice.<sup>66</sup>

In cases involving market relocation or avoidance, plaintiffs have generally lost.<sup>67</sup> It is difficult to contest a defendant's decision to move because of underlying socioeconomic changes and shifts in neighborhoods; similarly, it is very difficult to force a business to relocate to a money-losing market. In health care, this mixing of financial opportunities with discrimination is complicated by the fact that minority patients disproportionately are uninsured or rely on Medicaid, a notoriously poor health care payer.<sup>68</sup> Were Medicaid a good payer, a decision to move away from or avoid serving Medicaid patients might be questioned. But where Medicaid pays poorly, the need to avoid financial loss arguably leaves defendants no alternative but to flee the market or shift costs onto other payers, which is hardly a sound business practice.

For all of the reasons discussed, particularly the heavy burdens plaintiffs face in making their cases, private enforcement of Title VI is extremely difficult. We now discuss whether public enforcement of civil rights law in the health care setting has met with greater success.

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duty that would be considered acceptable, OCR attempted to do what individual plaintiffs in civil rights actions cannot do, namely, underscore the availability of options for conducting business that are calculated to minimize adverse impacts. This example of proactive guidance from the government stands in stark contrast to the basic record of inaction.

65. Rosenbaum et al., *supra* note 56; Watson, *supra* note 21.

66. Perez, *supra* note 22.

67. Rosenbaum et al., *supra* note 56.

68. See Stephen Norton & Stephen Zuckerman, *Trends in Medicaid Physician Fees, 1993-1998*, HEALTH AFF., July/Aug. 2000, at 222.

## II. THE CHALLENGE OF FEDERAL ENFORCEMENT OF TITLE VI

In this Part, we examine the scope and power of governmental enforcement by providing a brief review of where matters stood *vis-à-vis* Title VI enforcement at the time *Sandoval* was handed down.

In 1999—two years before the Supreme Court decided *Sandoval*—the United States Commission on Civil Rights (the Commission or USCCR) issued the results of a lengthy examination of U.S. civil rights enforcement in the area of health care.<sup>69</sup> The Commission was extremely harsh in describing the depths to which OCR had sunk by the end of the twentieth century. The Commission concluded that “the timid and ineffectual enforcement efforts of [OCR] have fostered, rather than combated, the discrimination that continues to infect the Nation’s health care system. This is evident in the segregation, disparate treatment, and racism experienced by African Americans, Hispanic Americans, Native Americans, Asian Americans and Pacific Islanders, and members of other minority groups. . . .”<sup>70</sup>

The Commission was careful not to assign all the blame for discriminatory conditions to OCR.<sup>71</sup> It pointed out that since government-sanctioned segregation was abolished in the aftermath of the 1964 Civil Rights Act—and with it the most visible forms of discrimination—racial inequality in health care had never been a top national priority. As such, it found that civil rights enforcement was afforded relatively little emphasis and was not seen as an integral part of HHS’s mission.<sup>72</sup> Similarly, the Commission determined that Congress and successive Presidents had essentially ignored OCR, failing to prioritize health care civil rights enforcement or offer any oversight or support. For example, as of 1999, Congress had not held an oversight hearing on OCR’s civil rights enforcement activities since 1987.<sup>73</sup> Consequently, OCR was found to suffer from both a lack of guidance and severe resource constraints, thus

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69. 2 U.S. COMM’N ON CIVIL RIGHTS, *supra* note 52. The Commission is an independent, bipartisan agency first established by Congress in 1957. Its investigation of civil rights enforcement efforts by HHS was undertaken pursuant to Public Law 103-419 (1994), which, in part, reauthorized the Commission and directed it to study, collect information relating to, and make appraisals of federal laws and policies regarding discrimination or denials of equal protection of the laws. Until the 1999 report, the Commission had not conducted a comprehensive evaluation of HHS. 1 U.S. COMM’N ON CIVIL RIGHTS, *supra* note 52, at iii.

70. *Id.* at 274.

71. *See id.* at 276.

72. *Id.*

73. *Id.*



impeding competent implementation of its civil rights enforcement responsibilities. In 1999, OCR's budget represented just 0.0054 percent of the entire HHS budget, and OCR had no separate budget for Title VI enforcement.<sup>74</sup> Between 1980 and the date of the report, the number of full-time OCR employees had dropped by some sixty percent.<sup>75</sup>

At the same time, and even more striking in the context of *Sandoval*, the Commission laid considerable blame at OCR's feet. Even with lower expectations in light of limited resources, the Commission found that OCR showed shameful neglect of its responsibilities.<sup>76</sup> Most frustrating to the Commission was OCR's unwillingness to address or attack its deficiencies, choosing instead to act sluggishly and unresponsively to increasing racial inequalities in health care. The Commission found that OCR had developed no Title VI guidelines and few policy directives, that it lacked a thorough pre-award review process to ensure that prospective recipients of federal financial assistance were in compliance with the law, that it rarely conducted post-award desk audit reviews and comprehensive onsite compliance reviews, that it had a growing complaint backlog, and that it lacked an effective and comprehensive system for monitoring corrective action commitments.<sup>77</sup> In other words, OCR was utterly incapable of doing its job.

The Commission also described many concerns with OCR's complaint investigation process. It found OCR regulations for complaint evaluation vague and overly broad, offering little or no guidance for employees.<sup>78</sup> Furthermore, OCR was found to lack thorough and rigorous investigative techniques and methodologies, particularly in ascertaining the difference in quality of health care provided across racial and ethnic lines.<sup>79</sup> Of particular concern in light of *Sandoval*, OCR staff had no clear policy guidance on how to conduct disparate impact analyses, and was generally unable to identify a "nexus" between existing disparities and a health care practice or policy.<sup>80</sup>

OCR was also found to sometimes demonstrate inattention to or ignorance of Title VI issues. The Commission recounted one incident in which OCR became involved in a Title VI disparate impact case entitled

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74. *Id.* at 292-93.

75. *Id.* at 27.

76. *See id.* at 276.

77. *See id.* at 240-45.

78. *Id.* at 173.

79. *Id.* at 184.

80. *Id.* at 184-85.

*Mussington v. St. Luke's-Roosevelt Hospital Center.*<sup>81</sup> At a community meeting about the case, one participant indicated that the hospital might have discriminated against Medicaid patients. Amazingly, the OCR investigator informed the audience that such discrimination was not illegal, according to an NAACP Legal Defense Fund attorney present at the meeting.<sup>82</sup>

From the Commission's viewpoint, however, perhaps the most distressing problem (and without doubt the most extraordinary of all the facts available to the Supreme Court at the time it decided *Sandoval*) is OCR's inability to effectively address and resolve complaints filed by alleged victims of race discrimination. Individuals who believe that they have been discriminated against on the basis of race, color, or national origin are entitled under federal regulations to file a complaint with OCR. Title VI regulations require OCR to establish procedures for the "prompt processing and disposition" of all complaints of discriminatory practices.<sup>83</sup> Yet despite this mandate, USCCR found that OCR "takes inordinate amounts of time to complete complaint investigations,"<sup>84</sup> with complaint files often open for three to six years. USSCR warned that,

[u]nlike the civil rights enforcement agencies that address discrimination in education and employment, OCR is responsible for uncovering discrimination that may affect not just one's life opportunities but on [sic] something far more profound—individuals' health and physical well-being. In some cases, prompt investigation could be a matter of life and death.<sup>85</sup>

This recounting of the inner workings of OCR illustrates a few basic points. First, the Commission's description of the agency's funding and staffing difficulties suggests that the dreadful financial and operational conditions within OCR are a fixture on the landscape of government enforcement and not a recent development. As Smith notes in his history of Title VI, the very establishment of OCR as an agency separate from the agencies directly administering federally financed programs amounted to a deliberate attempt on the part of some members of Congress (in particular, powerful members of the appropriations committees) to eviscerate civil rights enforcement efforts.<sup>86</sup> This separation of agencies was

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81. 824 F. Supp. 427 (S.D.N.Y. 1993), *aff'd*, 18 F.3d 1033 (2d Cir. 1994).

82. 2 U.S. COMM'N ON CIVIL RIGHTS, *supra* note 52, at 190.

83. 28 C.F.R. § 42.408(a) (2001).

84. 2 U.S. COMM'N ON CIVIL RIGHTS, *supra* note 52, at 189.

85. *Id.*

86. SMITH, *supra* note 23, at 164–66.

a direct response to active efforts by the Department of Health, Education, and Welfare to achieve civil rights compliance within the health care industry in the wake of Medicare's enactment.<sup>87</sup> Over time, the decision to centralize civil rights operations and remove civil rights enforcement from day-to-day program administration has had precisely its intended effect.

Second, to the extent that anyone expects that a renewed commitment to active government intervention in the face of health care inequality could occur through OCR, the Commission's analysis of the agency's structure and capability should dash this expectation. There are no standards of conduct in the area of health care—one of the largest sectors of the U.S. economy<sup>88</sup>—other than a handful of broadly crafted regulations that are nearly forty years old and a very small amount of informal policy guidance, even though OCR has the authority to craft specific standards.<sup>89</sup> There is no system for measuring the presence of discrimination. And there is no systematic enforcement strategy that could withstand most defenses raised by a recipient of federal financial assistance, particularly in light of the broad nature of the affirmative “legitimacy” defense. Under this defense, a defendant could show in *de facto* cases (both those brought by private litigants and by OCR) that even high levels of segregation and unequal treatment stem from a legitimate business need.<sup>90</sup>

But beyond the obvious need to maintain an office for civil rights that is not a positive embarrassment, a perhaps deeper question concerns the limits of what could be accomplished through a reinvigorated Title VI standard-setting and enforcement machinery, if such machinery were housed within OCR. The fact is that, even were OCR to be significantly expanded in size and resources, the agency still would be understood as having no real power over the thousands of basic, day-to-day decisions regarding the standards of performance that federally assisted entities must meet. Because OCR has never been given the formal task of administering federal funding programs (in the way, for example, that the HHS Health Resources and Services Administration administers the Community Health Center Program or CMS administers the Medicare

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87. *Id.* For a similar view and excellent treatment of the need for litigation to address racial and ethnic disparities in health care, see 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 (2001).

88. Health care spending accounts for 14% of the United States's gross domestic product. Lado, *supra* note 87, at 10.

89. See, for example, the regulations regarding limited English proficiency, *supra* note 11; *supra* text accompanying note 44.

90. See Watson, *supra* note 21, at 962.

Program), its pronouncements over their standards of performance are understandably perceived as having only limited meaning. Furthermore, having worked closely with OCR officials over the years, it is our sense that many of them believe that even if the agency were given the personnel and resources to actively enforce its modest collection of standards in the health care arena, its activities would continue to be viewed as somehow separate and apart from the basic standards of performance guiding health spending, not only by the entities that receive federal funds, but by the sister agencies that administer the programs as well.

This sense of futility is underscored by a perusal of the thousands of pages of federal regulations applicable to federal health care financing programs. For example, although Title VI compliance is a condition of federal funding, this simple fact is not stated anywhere in federal regulations governing Medicare's conditions of participation. To offer one illustration, the Medicare conditions of participation for hospitals open with a threshold regulation that obligates participating facilities to be in compliance with "federal laws related to the health and safety of patients."<sup>91</sup> The fact that, in order to receive any federal funds, hospitals as a first matter must be in compliance with federal laws related to the equal treatment of patients regardless of race or national origin goes unmentioned. Even the Medicare regulation that establishes hospitals' legal obligation to honor "patients' rights" fails to make any mention of the right to equal treatment regardless of race or national origin.<sup>92</sup>

The same marked absence of any indication of the obligation to be in compliance with Title VI—or what that obligation means in a health care context—is evident throughout the hundreds of pages of Medicare conditions-of-participation regulations applicable to all forms of health care providers and entities.<sup>93</sup> Nor do the rules require that the entity attest to its compliance with Title VI at the time that it makes a claim for payment.<sup>94</sup>

Time and again, recipients of federal financial assistance issue policies that appear facially neutral (i.e., they make no mention of racial identification) but are capable of producing devastating racial effects. The

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91. 42 C.F.R. § 482.11 (2002).

92. 42 C.F.R. § 482.13 (2002).

93. *See, e.g.*, Requirements Relating to Health Insurance Coverage, General Provisions, 45 C.F.R. § 114.103 (2002); Requirements Relating to Access and Renewability of Coverage, 45 C.F.R. § 146.113 (2002); Requirements for the Group Health Insurance Market, Exclusion of Plans and Enforcement Requirements, 45 C.F.R. § 146.180 (2002).

94. 42 C.F.R. §§ 424.30. (2002).

selection of markets is a clear area of concern, as the past two decades of litigation related to hospital closures and relocation underscore.<sup>95</sup> Yet in 2001, and with no discussion of the potential disproportionate effects on minority beneficiaries, the Bush Administration announced a new policy that would permit Medicare+Choice organizations to identify their service areas on a sub-county basis.<sup>96</sup> This policy, while clearly linked to an effort to hold on to a declining market, also appears to explicitly sanction redlining of racially identifiable portions of a community in favor of healthier and more affluent residents. The notion that race is linked to poor health and high cost is deeply embedded in the insurance industry despite years of efforts to prohibit racial profiling.<sup>97</sup>

Most striking perhaps from the standpoint of the modern health care system is the absence of any reference to the basic obligation to abide by Title VI regulations in the rules governing the sub-contractual arrangements maintained by covered entities such as hospitals, nursing homes, managed care organizations and other corporate health care providers. As noted previously, Title VI regulations reach not only entities but their contractors as well. This reach has become even more important in light of the formation of ever more complex corporate health care entities held together through a cascade of interlocking contracts. The absence of clear prohibitions within the Medicare rules against contracts with business partners that discriminate is striking. This is true not only because it is a specific standard that is directly compelled by basic civil rights law, but also because of the level of awareness within HHS today of the extent to which covered entities can use contracts with otherwise uncovered actors to avoid the purposes and intent of a federal law.<sup>98</sup>

The same observations can be made about federal rules governing Medicaid and the State Children's Health Insurance Program (SCHIP). The fact that compliance with Title VI is a basic condition of participation for any state agency, program, or health care provider receiving federal funding under these programs is simply absent from federal rules. Even

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95. See, e.g., *Bryan v. Koch*, 492 F. Supp. 212 (S.D.N.Y. 1980); *NAACP v. Wilmington Med. Ctr., Inc.*, 491 F. Supp. 290 (D. Del. 1980).

96. Hans R. Dutt et al., *The Financial Implications of HMOs' Partial County Carve-Out Option*, 14 *MANAGED CARE INTERFACE* 46 (2001).

97. Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 *J. HEALTH POL., POL'Y & L.* 287 (1993).

98. In fact, this theme of binding the contractual business partners of a covered enterprise has dominated the federal government's health care privacy rules. See *Standards for Privacy of Individually Identifiable Health Information*, 67 *Fed. Reg.* 14,776 (proposed March 27, 2002).

worse, in the case of Medicaid there are situations in which CMS has actively condoned the segregation of Medicaid beneficiaries—who are of course disproportionately minority—into separate systems of care within a single health care enterprise.

The federal regulations governing the SCHIP program illustrate a broader failure on the part of federal agencies to think through the racial implications of federal spending standards. Generally speaking, SCHIP gives participating states two basic administration options. A participating state may elect to implement SCHIP as an extension of its Medicaid program, or it may cover some or all SCHIP-eligible children through a separate state plan with its own distinct eligibility, benefit, provider-participation, and other requirements. As of the end of 2001, approximately two-thirds of all states administered their SCHIP programs separately either in whole or in part (e.g., extending Medicaid coverage up to the federal poverty level for all children under 18 and enrolling near-poor children in a separate program).

The demographics of childhood poverty mean that in many states and communities, the poorest children (i.e., Medicaid children) are more likely to be minority children while the near-poor children (those potentially covered by SCHIP) are more likely to be non-minority. Whatever their race, children have the potential to move between the two programs as their family income fluctuates from year to year. Given the fluctuation in income that characterizes many low-income households, and the importance of continuity in pediatric care, one would imagine that, for both the prevention of bias in provider participation and the promotion of health quality, CMS would have addressed the issue of state contracting practices with health care providers and entities. In fact, the regulations are completely silent on the issue of whether a state agency can enter into agreements under its separate SCHIP program with entities that refuse to participate in Medicaid. The regulations do not even require states to be able to demonstrate that they have in place a series of standards and incentives to promote dual participation or discourage non-participation in Medicaid.

The most egregious example of rules that foment discrimination is a proposed rule, issued by the Bush Administration in August 2001,<sup>99</sup> that would reverse an earlier Medicaid managed care rule promulgated by the Clinton Administration. The earlier rule prohibited state agencies from

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99. Medicaid Program; Medicaid Managed Care, 66 Fed. Reg. 43,614 (proposed Aug. 20, 2001), available at <http://www.hcfa.gov/medicaid/cms2104p.pdf> (last visited Mar. 30, 2003).

maintaining contracts with Medicaid managed care organizations and entities that maintained segregated provider networks (i.e., separate networks based on source of payment). The intent of this earlier rule was to prevent participating entities from excluding members from certain portions of their network (and at least by logical extension, as a means of discouraging managed care entities from contracting with health providers that refuse to treat Medicaid patients). This type of exclusionary and segregating practice bears striking similarities to the older and well-documented practices involving segregated hospital floors, segregated medical staffs, and segregated nursing home wings, all of which unquestioningly violate Title VI. Without explanation, the 2001 regulation proposed to simply eliminate the prohibition.

Similarly, the Clinton Administration's final Medicaid managed care regulations sought to address the problem of language and culture access in managed care by requiring participating entities in federal health programs to be able to demonstrate the existence of various approaches to cultural competency.<sup>100</sup> Yet the Bush Administration's 2002 Final Rule eliminated these relatively precise requirements in favor of virtually no standards other than a vague reference to cultural competence.<sup>101</sup> As with the segregated networks rule, this change was proposed with virtually no explanation in the Preamble to the proposal.<sup>102</sup>

A final example of the extent to which federal participation and payment rules ignore or even undermine Title VI obligations can be found in Medicaid rules applicable to provider payment. As a matter of federal law, a state Medicaid program must maintain provider payment levels that are sufficient to ensure reasonable access by beneficiaries, with the reasonableness of the access measured in terms of access to the same services by comparable populations.<sup>103</sup> The federal Medicaid equal-access regulations arguably have two statutory bases: the federal Medicaid statute that sets the standard, and Title VI, which reinforces these regulations because of Medicaid's disproportionate minority racial and ethnic composition. Despite the fact that inadequate beneficiary access to health providers is epidemic and the subject of widespread discussion,<sup>104</sup> CMS has

100. 42 C.F.R. § 438.10 (2000).

101. Medicaid Program; Medicaid Managed Care, 67 Fed. Reg. 40,989, 41,106 (June 14, 2002), codified at 42 C.F.R. § 438.206(c)(2).

102. Medicaid Program; Medicaid Managed Care, 67 Fed. Reg. 40,989 (June 14, 2002).

103. 42 U.S.C. § 1396a(a)(30) (2003).

104. *See, e.g.*, EDWIN PARK & LEIGHTON KU, CTR. ON BUDGET & POLICY PRIORITIES, ADMINISTRATION MEDICAID AND SCHIP WAIVER POLICY ENCOURAGES STATES TO SCALE BACK

never issued a written clarification stating that the obligation to ensure equal access stems not only from federal Medicaid law but also from the equality in treatment dimensions of civil rights law (i.e., Title VI) itself.

In sum, it is difficult to overstate the extent to which the major federal health care financing agencies, and CMS in particular, have ignored Title VI considerations in setting policy. Even where OCR has attempted to step in to fill the breach, its efforts have had little effect since the delegation of powers within HHS gives OCR no power to make program policy with respect to health care financing. This enormous paradox—the assignment of responsibility for enforcing federal civil rights laws applicable to federal spending to an agency that has no powers to set the standards for federal spending—results in a problem far worse than inaction. It effectively excuses the very agencies with day-to-day responsibility to keep federal spending in line with federal law. Even worse, this state of affairs encourages willful ignorance of civil rights laws in the setting of performance standards and in the establishment of procedures for measuring compliance.

### III. ALEXANDER V. SANDOVAL

In spite of the already-significant hurdles facing both private and public Title VI enforcement, the United States Supreme Court's decision in *Alexander v. Sandoval*<sup>105</sup> sent shockwaves through the civil rights community.<sup>106</sup> By abrogating the right of individuals to bring private

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BENEFITS SIGNIFICANTLY AND INCREASE COST-SHARING FOR LOW-INCOME BENEFICIARIES (2001), available at <http://www.cbpp.org/8-15-01health.htm> (last visited Apr. 3, 2003); Bruce E. Landon & Arnold M. Epstein, *Quality Management Practices in Medicaid Managed Care: A National Survey of Medicaid and Commercial Health Plans Participating in the Medicaid Program*, 282 J. AM. MED. ASS'N 1769 (1999); Robert Pear, *Many on Medicaid Lack Drugs, Study Says*, N.Y. TIMES, Apr. 9, 2002, at A20.

105. 532 U.S. 275 (2001).

106. See, e.g., Press Release, American Civil Liberties Union, Two Supreme Court Rulings Expand Police Powers and Limit Civil Rights Enforcement (Apr. 24, 2001), available at <http://www.aclu.org/news/2001/n042401c.html> (last visited Mar. 28, 2003) ("In one fell swoop, the Court has both increased the potential for racial profiling and diminished 30 years of civil rights law designed to protect victims of discrimination."); Press Release, Progressive Coalition for Equal Opportunity and Justice, Supreme Court Decision on English-Only Law a Blow to Civil Rights and Women of Color (Apr. 24, 2001), available at <http://www.civilrights.org/library/detail.cfm?id=4892> (last visited Apr. 8, 2003) (noting that *Sandoval* represented "a major set back [sic] for those who want to combat discrimination in this country," and that the "decision has troubling implications for our civil rights laws in many areas").



actions under Title VI to enforce the disparate impact regulations, the decision effectively wiped out two decades of Title VI litigation.<sup>107</sup> While the decision left unanswered the question of whether a private right of action could be pursued under alternative legal theories in the case of public agencies,<sup>108</sup> it eviscerated actions against private entities that receive federal funds,<sup>109</sup> which in the case of health care is an enormous matter.

The *Sandoval* case began life as a relatively routine (in the sense that it typified Title VI cases) class action. The lawsuit was filed in December 1996 by non-English-speaking residents of Alabama, who claimed that the state's Department of Public Safety discriminated against them on the basis of national origin by refusing to offer drivers' licensing exams in any language other than English. The plaintiffs alleged that although Alabama's law was facially neutral—it did not explicitly prohibit non-English-speaking individuals from taking the licensing exam and therefore was not intentionally discriminatory—its *effect* was to discriminate against those individuals who hailed from countries where English was not spoken. Because the claim was one of discriminatory impact, it arose under the federal regulations promulgated pursuant to Title VI rather than under the statute itself (since the statute proscribes only intentional discrimination, while its implementing regulations prohibit conduct that is neutral in motive but discriminatory in effect). After the District Court for the Middle District of Alabama ruled that the English-only policy could not be enforced,<sup>110</sup> the United States Court of Appeals for the Eleventh Circuit affirmed the decision.<sup>111</sup> The U.S. Supreme Court then granted certiorari to the Director of Alabama's Department of Public Safety.

107. As described *supra* in note 53, every federal circuit court of appeals to address the question in *Sandoval* concluded that a private right of action exists to enforce Title VI and its regulations.

108. The Court did not reach the question of whether individuals could sue for Title VI violations under 42 U.S.C. § 1983, which provides a cause of action against anyone who, acting under color of state law, causes deprivations of "rights . . . secured by the Constitution and laws." (In the wake of *Sandoval*, however, some lower federal courts have ruled that plaintiffs cannot use § 1983 to enforce Title VI rights. *See, e.g.*, *Foster Children Bonnie L. v. Bush*, 180 F. Supp. 2d 1321 (S.D. Fla. 2001) (plaintiffs' § 1983 claim could not survive *Sandoval*); *South Camden v. New Jersey Dep't of Env'tl. Prot.*, 274 F.3d 771 (3d Cir. 2001) (administrative regulation cannot create an interest enforceable under § 1983 unless the interest is already implicit in the statute authorizing the regulation)). Thus, even if such a suit were viable, only a portion of health care providers could be targeted under § 1983.

109. *Alexander v. Sandoval*, 532 U.S. 275 (2001).

110. *Sandoval v. Hagan*, 7 F. Supp. 2d 1234 (M.D. Ala. 1998).

111. *Sandoval v. Hagan*, 197 F.3d 484 (11<sup>th</sup> Cir. 1999).

Writing for the narrowest of majorities, Justice Scalia maintained that the text and structure of Title VI evidenced congressional intent to separate the means of enforcement in cases of intentional and *de facto* discrimination.<sup>112</sup> In particular, according to Scalia's reading, private enforcement of Title VI is available only for intentional discrimination. This reading is not obvious, however, given that Title VI makes no mention of private enforcement whatsoever.

The majority achieved this legal sleight-of-hand by reasoning that since the statute explicitly outlaws only intentional discrimination, the regulations cannot be seen as an extension of Section 601. They must instead be an extension of "the independent force"<sup>113</sup> of Section 602, which empowers federal administrative agencies to enforce the law through regulations. Having located the prohibition against *de facto* discrimination in Section 602, the Court holds that because this provision is limited to ensuring *agencies'* ability to effectuate Section 601, Congress could not have intended to include *private* enforcement rights as an option under Section 602. Justice Scalia argues that the plain language of Section 602 "focus[es] neither on the individuals protected nor even the funding recipients being regulated, but on the agencies that will do the regulating."<sup>114</sup> In sum, Section 602's focus on the regulatory process, coupled with the absence of explicit language creating a private right of action, was sufficient to satisfy the Court that Congress intended no private right of enforcement.

The Court's decision brushes aside any analysis of the context in which Title VI was enacted, declining with remarkable brevity the opportunity to examine Title VI's legislative history because "legal context matters only to the extent it clarifies text."<sup>115</sup> In fact, in one of the more insulting passages in any Court decision in recent memory, Justice Scalia frames the argument of the individuals who brought the action in terms of a drunk who has had one drink too many: "Respondents would have us revert in this case to the understanding of private causes of action that held sway 40 years ago when Title VI was enacted. . . . Having sworn off the habit of venturing beyond Congress's intent, we will not accept respondents'

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112. 532 U.S. at 287–88.

113. *Id.* at 286.

114. *Id.* at 289.

115. 532 U.S. at 288. For examples of the Court's willingness to rigorously consider legal context in analyzing federal statutes, see *Merrill, Lynch, Pierce, Fenner & Smith, Inc. v. Curran*, 456 U.S. 353 (1981) (holding that Commodities Exchange Act provides implied right of action) and *Cannon v. Univ. of Chicago*, 441 U.S. 677 (1979) (holding that Title VI creates private right of action).

invitation to have one last drink.”<sup>116</sup> In effect, the Court took the position that the entire history underlying congressional intent in enacting Title VI did not matter to its interpretation of the statute.

The Court’s treatment of precedent was no more deferential. In considering the extensive Supreme Court case law in the area of civil rights enforcement, the Court failed to apply the hypercritical scrutiny to which it had subjected the text of Title VI, a failure for which it was roundly criticized in the dissent.<sup>117</sup> Justice Scalia refused to acknowledge that his approach was ad hoc, however, insisting that the “Court is bound by holdings, not language.”<sup>118</sup>

The reasoning of the Court thus leaves persons who allege *de facto* discrimination in the position of having legal protections but no effective legal remedy other than the discretionary and grossly under-staffed federal enforcement machinery. This outcome—that there can be individual legal protections without adequate means of enforcement—is one that runs counter to long-standing principles of statutory interpretation regarding the existence of private rights of action.<sup>119</sup> The Court’s decision to remove direct access to court as a remedy in *de facto* discrimination situations also runs counter to the approach taken by every federal appeals court in considering whether a private right of action exists to enforce regulations issued pursuant to Title VI, including the disparate impact regulations.<sup>120</sup>

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116. 532 U.S. at 287

117. For example: “In a decision unfounded in our precedent and hostile to decades of settled expectations, a majority of this Court carves out an important exception to the right of private action long recognized under Title VI.” *Id.* at 294 (Stevens, J., dissenting); “The majority’s statutory analysis does violence to both the text and the structure of Title VI.” *Id.* at 304 (Stevens, J., dissenting); “In order to impose its own preferences as to the availability of judicial remedies, the Court today adopts a methodology that blinds itself to important evidence of congressional intent.” *Id.* at 313 (Stevens, J., dissenting).

118. *Id.* at 282.

119. For example, it was not uncommon during the era of the Civil Rights Act’s passage for courts to hold that private rights of action existed even when Congress created a statute with ambiguous or vague enforcement provisions (and, furthermore, to oftentimes do so without performing a detailed analysis of the statute’s enforcement provisions). *See, e.g.*, *Hewitt-Robins Inc. v. E. Freight-Ways, Inc.*, 371 U.S. 84 (1962) (implied right of action under Motor Carrier Act); *Allen v. State Bd. of Elections*, 393 U.S. 544 (1969) (Voting Rights Act of 1965); Susan J. Stabile, *The Role of Congressional Intent in Determining the Existence of Implied Private Rights of Action*, 71 NOTRE DAME L. REV. 861 (1996). *See also* Donald H. Zeigler, *Rights, Rights of Action, and Remedies: An Integrated Approach*, 76 WASH. L. REV. 67 (2001).

120. For decisions so holding most explicitly, *see, e.g.*, *Sandoval v. Hagan*, 197 F.3d 484

The dissent, authored by Justice Stevens and joined by Justices Souter, Ginsburg, and Breyer, assails the majority's holding as untenable, and displays an antagonism reserved for the most contentious of the Court's cases. Justice Stevens finds particular fault with three elements of the majority opinion: its "muddled" account of prior Supreme Court Title VI decisions, its "flawed and unconvincing" analysis related to the division of Sections 601 and 602, and its misinterpretation of an earlier Title IX decision key to the majority's opinion.<sup>121</sup>

Mainly, however, the dissent argues that although the statutory text of Title VI might be narrower in scope than its implementing regulations, there is nothing to suggest that Congress intended the statute to operate in isolation from the regulations; indeed, the very link between the prohibition of Section 601 and the assignment of standard-setting and enforcement duties in Section 602 argues against such a result.<sup>122</sup> Reviewing the history of the Civil Rights Act, Justice Stevens notes that the legislative design of Title VI countenanced a flexible approach to combating discrimination. Indeed, the very fact that the statute specifically instructs agencies to promulgate rules that effectuate legislative intent underscores the validity of extending private rights of action to any class of legal violation, not just certain types of misconduct. Specifically,

the statute does not establish a static approach but instead empowers the relevant agencies to evaluate social circumstances to determine whether there is a need for stronger measures. Such an approach builds into the law flexibility, an ability to make nuanced assessments of complex social realities, and an admirable willingness to credit the possibility of progress.<sup>123</sup>

The dissent views the statute and regulations as "inseparably

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(11th Cir. 1999); *Powell v. Ridge*, 189 F.3d 387, 400 (3d Cir. 1999); *Chester Residents Concerned for Quality Living v. Seif*, 132 F.3d 925, 936-37 (3d Cir. 1997), *vacated*, 524 U.S. 974 (1998); *David K. v. Lane*, 839 F.2d 1265, 1274 (7th Cir. 1988). *See also* *Ferguson v. Charleston*, 186 F.3d 469 (4th Cir. 1999), *rev'd on other grounds*, 532 U.S. 67 (2001); *Buchanan v. Bolivar*, 99 F.3d 1352, 1356 n.5 (6th Cir. 1996); *Villanueva v. Carere*, 85 F.3d 481, 486 (10th Cir. 1996); *New York Urban League, Inc. v. New York*, 71 F.3d 1031, 1036 (2d Cir. 1995); *Latinos Unidos De Chelsea v. Sec'y of Hous. & Urban Dev.*, 799 F.2d 774, 785 n.20 (1st Cir. 1986); *Castaneda v. Pickard*, 781 F.2d 456, 465 n.11 (5th Cir. 1986); *Larry P. v. Riles*, 793 F.2d 969, 981-82 (9th Cir. 1986). No court of appeals has ever reached a contrary conclusion.

121. 532 U.S. at 295 (Stevens, J., dissenting).

122. *Id.* at 303 (Stevens, J., dissenting).

123. *Id.* at 306 (Stevens, J., dissenting).

intertwined” into a flexible and sensible remedial scheme to ensure that recipients of federal aid do not discriminate against minorities, no matter the type of discrimination.<sup>124</sup> For this reason, the dissent finds it legally implausible to differentiate between private actions to enforce Section 601 and private actions to enforce Section 602.<sup>125</sup>

In sum, the *Sandoval* decision is a case of enormous legal consequence, and another in a series of Supreme Court cases that diverge from decades of civil rights history in order to achieve a result that is consistent with the modern Court’s desire to withdraw the judicial system from disputes involving the alleged abrogation of individual legal rights by government actors.<sup>126</sup> Because Title VI also reaches private conduct by recipients of federal financial assistance, the case is of equal importance to instances in which the alleged wrong is committed by a private entity.

Of course, at first blush, it might appear that the Court’s withdrawal of a private right of action to enforce the Title VI disparate treatment rule would be of little consequence in a health care context, in light of the relatively limited use of Title VI in the private health litigation context, the rarity of victory when cases are mounted, and the potential advantages of a strong federal enforcement presence.<sup>127</sup> But this conclusion overlooks the vital role that litigation—and the threat of litigation—has played in bringing about change through negotiated settlements even when an outright victory may not have been possible.<sup>128</sup> Furthermore, as we have

124. *Id.* (Stevens, J., dissenting).

125. *Id.* at 310 (Stevens, J., dissenting).

126. *See, e.g., Bd. of Trs. v. Garrett*, 531 U.S. 356 (2001) (holding that the Eleventh Amendment’s sovereign immunity protections bar individuals from suing states that failed to provide disability accommodation). Furthermore, the *Sandoval* opinion evinces a willingness of a majority of the Court to depart from long-standing tradition in another context—that of broadly construing remedial civil rights statutes. *See, e.g., Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 105 (1989) (holding that § 1983 is to be broadly construed); *Trafficante v. Metro. Life Ins. Co.*, 409 U.S. 205, 211–12 (1972) (holding that the Fair Housing Act is to be broadly construed). This departure includes the Court’s efforts to obliterate implied private rights of action. *See, for example, Washington v. Davis*, 426 U.S. 229 (1976), and its progeny. It is also worth noting that the decision may also foreshadow a review of the validity of the disparate impact regulations themselves, since the Court only *assumes* for purposes of deciding *Sandoval* that the regulations are valid. 532 U.S. at 525.

127. *See* discussion *supra* Part II.

128. For example, negotiations in hospital relocation cases such as *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135 (Del. 1961) and *Bryan v. Koch*, 627 F.2d 612 (2d Cir. 1980) resulted in crucial concessions over the establishment of satellite clinics, transportation to new

seen,<sup>129</sup> federal government enforcement capabilities where potential Title VI health care violations are concerned are so devastatingly constrained that it is difficult to overstate the futility of relying on the government to do its job in its current state.<sup>130</sup> These facts could not have been lost on the *Sandoval* majority, given the abundance of evidence from years of oversight investigations into government civil rights enforcement efforts (or the lack thereof).<sup>131</sup> This knowledge regarding the sorry state of affairs where civil rights enforcement is concerned makes the decision all the more unfortunate.<sup>132</sup>

Taken to its logical conclusion, the majority decision in *Sandoval* could be read as abrogating all private actions involving the enforcement of any congressionally sanctioned federal regulation that extends beyond the literal text of its parent statute.<sup>133</sup> This approach to statutory interpretation has no foundation in Supreme Court precedent but will likely be proffered by institutional defendants in a wide range of subsequent litigation, particularly in cases in which federal enforcement machinery is inadequate (see *supra* Part II) and the withdrawal of individual actions realistically means the denial of any remedy at all.

In fact, just two years after being handed down, *Sandoval's* impact on civil rights litigation generally serves as a harbinger of the systematic deprivation of individual rights possible under the decision. Defendants in pending civil rights litigation have asked federal courts to dismiss claims and reconsider orders granting plaintiffs injunctive relief, and plaintiffs—unable to remedy alleged disparate impact discrimination through Section 602 enforcement—have moved to amend complaints against public defendants to add a Section 1983 claim. The *Sandoval* ruling has thus limited not only the civil rights claims adjudicated under Title VI<sup>134</sup> of the

facilities, and other changes.

129. See discussion *supra* Part II.

130. SMITH, *supra* note 23; 2 UNEQUAL TREATMENT, *supra* note 15, at 3, 29–30.

131. 2 U.S. COMM'N ON CIVIL RIGHTS, *supra* note 52.

132. See generally Lado, *supra* note 87.

133. See, e.g., *Litman v. George Mason Univ.*, 156 F. Supp. 2d 579 (E.D. Va. 2001) (holding that *Sandoval* bars private enforcement of Title IX's anti-retaliation regulations, since Congress intended Title IX to be interpreted and enforced in the same manner as Title VI).

134. *South Camden v. New Jersey Dep't of Env'tl. Prot.*, 274 F.3d 771 (3d Cir. 2001) (using *Sandoval* as its guidepost and holding that an administrative regulation cannot create an interest enforceable under § 1983 unless the interest is already implicit in the statute authorizing the regulation); *Foster Children Bonnie L. v. Bush*, 180 F. Supp. 2d 1321 (S.D. Fla. 2001) (ruling that plaintiffs' § 1983 claim could not survive *Sandoval*, since holding that

Civil Rights Act, but also those adjudicated under Title IX of that Act,<sup>135</sup> the Americans with Disabilities Act (ADA),<sup>136</sup> and the Rehabilitation Act.<sup>137</sup> Although a full review of the case law emanating from those claims is beyond the scope of this Article, the results paint a disturbing picture.

#### IV. CONCLUSION

By eliminating the right of individuals to enforce their constitutional protection against facially neutral practices that have a disproportionate adverse impact, *Sandoval* inevitably focuses attention on the obligation of government to address this type of systemic discrimination. Thus, as sobering as the *Sandoval* decision is from a civil rights enforcement standpoint, it conceivably could have a significant positive effect if it causes policy makers to re-focus their attention on the role of federal enforcement in ensuring civil rights.

But it should not have taken the rescission of an individual right of action to incite a basic rethinking of the federal enforcement of civil rights laws. It is evident from even a cursory reading of the original Title VI disparate impact rules that they were aimed at preventing entire industries and programs from operating without considering the racial consequences of their conduct. This goal can upon occasion be reached through individual litigation on behalf of classes of individuals. But the task of forcing large interests to confront and remedy the racial harms that can flow from facially neutral practices is surely best achieved through

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the regulations are privately enforceable under § 1983 but not under § 602 would be equivalent to holding that Congress intended the disparate impact regulations to be enforceable against state actors, but not private entities).

135. *Litman v. George Mason Univ.*, 156 F. Supp. 2d 579 (E.D. Va. 2001) (holding that *Sandoval* bars private enforcement of Title IX's anti-retaliation regulations, since Congress intended Title IX to be interpreted and enforced in the same manner as Title VI); *Atkinson v. Lafayette Coll.*, No. 01-CV-2141, 2002 U.S. Dist. LEXIS 1432, at \*8 (E.D. Pa. Jan. 29, 2002) (finding that in the wake of *Sandoval* there is no private right of action under Title IX to enforce its anti-retaliation regulations). A question left open in these cases, and not decided by the Supreme Court in *Sandoval*, is whether an agency may enforce the regulations against a state entity.

136. *Access Living of Metro. Chicago v. Chicago Transit Auth.*, No. 00-C0770, 2001 U.S. Dist. LEXIS 6041 (N.D. Ill. May 9, 2001) (ruling that plaintiffs presented sufficient evidence to rebut defendant's motion for summary judgment but noting that, in light of *Sandoval*, plaintiffs would likely not have an enforceable disparate impact discrimination cause of action under the Americans with Disabilities Act).

137. *Id.*

concerted action by government agencies which can use their spending powers to generate systemic and structural changes.

To this end, it is inappropriate that the government assigns such an important task to a small and isolated federal agency like OCR, which has no day-to-day administrative authority over federal spending. Why should a state agency or a major health enterprise listen to what this isolated entity has to say, other than perhaps out of some abstract belief that federal civil rights laws are important? Nothing in the daily grind of ensuring that one's health care operations are in compliance with federal rules appears to tie Title VI requirements to the basic operating standards that a health program has to meet, particularly since the Title VI standards have never been clearly articulated in a health context.

For both practical and political reasons, we believe that the primary government tools for instigating deliberate efforts to achieve equality in health care must be the same agencies that are empowered to shape programs. As can be seen from the foregoing discussion, existing standards applicable to the federal health insurance programs are rife with examples of failures on the part of the federal government to view policy decisions through a Title VI lens. Some decisions positively undermine the systemic and structural goals of Title VI by inviting redlining, exclusion, segregation, and other types of discriminatory treatment.

Using the response to the *Olmstead* decision (in which the Supreme Court ruled that medically unjustifiable institutionalization of disabled individuals under public programs constituted illegal discrimination)<sup>138</sup> as an example, we believe that cross-agency commitment to civil rights enforcement is essential if the federal government is to achieve results. This cross-agency role begins with a clear statement from Congress that it is no longer acceptable to assign the daily obligation to ensure compliance with federal laws to a single weak and dysfunctional agency. Since (as David Barton Smith so eloquently shows) it was congressional pressure in the latter half of the 1960s that caused the diminution of enforcement activity,<sup>139</sup> an important first step in creating a new cross-agency commitment to civil rights enforcement lies with the current Congress, which should articulate an expectation that all agencies develop a viable approach to compliance. In the case of HHS, this means that, in the rules governing the agency's federal appropriation, there should be language that makes clear that lawmakers anticipate a Department-wide strategy for civil rights enforcement. Such a strategy would not be limited to

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138. See *supra* text accompanying notes 2-3.

139. SMITH, *supra* note 23.



investigation of individual cases but would extend also to the development of prospective standards of conduct that guide programs and providers in understanding how civil rights regulations apply in a health care context.

Given the magnitude of the problem, the most sensible approach for the Department would be to follow the example that it set in *Olmstead*. In the aftermath of that Supreme Court decision, HHS leadership convened an interagency task force whose mandate went beyond figuring out ways to monitor and measure compliance with the decision. The goal of the HHS-wide working group in the case of *Olmstead* has been to move the world of federally assisted programs closer to the community integration goals of the Americans with Disabilities Act through a fundamental and systemic examination of existing federal policies. This effort to identify and address inadequate or flawed federal standards began with the Clinton Administration but has flowered under the Bush Administration, culminating in a series of policy statements, reports, technical assistance efforts, and other activities aimed not only at effectuating change but also at conveying the importance of change to recipients of federal funds.<sup>140</sup>

A parallel effort is no less important in the case of Title VI. In the post-*Sandoval* era especially, there is a need for a Department-wide effort that examines every aspect of the standards governing federal financial assistance to health programs and health care entities. In light of the market-based nature of the American health care system, a Department-wide review must focus on the basic mechanics of health care purchasing, and in particular on the elements of purchasing that are intrinsic to any transaction in health care today: market rules of entry (e.g., conditions of initial participation or grant awards for health professions training programs or biomedical research), contracting and performance standards (e.g., quality improvement criteria), and payment standards. These basic operating rules are precisely the type of "facially neutral" practices that can have a disproportionate adverse impact on racially identifiable subgroups, particularly in the case of practices that exclude or impede persons from accessing Medicaid or low-income Medicare programs. Given that certain systemic practices that are basic to structuring and operating the modern healthcare enterprise are prone to fall with disproportionate weight on groups that are correlated with race (e.g., Medicaid beneficiaries, low-

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140. To be sure, disability rights advocates would take issue with an overly rosy picture of the progress made to date, and many would argue that the progress has been too slow and that successive administrations have not done enough to press for community integration reform. But when one compares the federal government's response to *Olmstead* to its post-*Sandoval* performance, the result is positively sobering.

income Medicare beneficiaries), we believe that particularly strong Departmental attention should be given to the features governing the *location* and *functioning* of health care entities. We describe below the sorts of questions HHS should consider in regulating these features:

1. *Market entry*:<sup>141</sup> What basic standards should be in place in any health care institution? In communities in which the Medicaid population is disproportionately minority, should an entity that seeks to participate in Medicare be expected to also participate in Medicaid? Should an entity be able to subdivide markets to avoid service areas that are disproportionately minority? Should Medicare+Choice entities be permitted to avoid certain communities and, if so, on the basis of what evidence? What reasonable alternatives must an entity seeking to control the extent of its market (either geographically or by payer source) be obligated to consider? What are the acceptable grounds for rejecting alternative and less potentially discriminatory approaches?

2. *Contracts with business partners*: What showings must a federally participating entity (whether a state agency or a private health care corporation) be required to make about its contractual business partners? Can an SCHIP agency do business with a health corporation that does not participate in Medicaid? Can an SCHIP-participating managed care organization contract with providers that refuse to treat Medicaid beneficiaries, and if so, under what conditions? Can a Medicare+Choice organization maintain contracts with providers that will not treat dually enrolled Medicare/Medicaid beneficiaries who need Medicaid to cover compulsory cost-sharing? What data must business partners provide about their conduct and practices?

3. *Payments*: What standards should apply to the payment practices of both public agencies and federally assisted health care corporations and entities? Should a state agency ever be able to pay at less than demonstrably actuarially reasonable rates for managed care enrollment, nursing home services, or physicians' services? If so, under what circumstances? Should a health care corporation that participates in federal programs be permitted to establish differential payment rates by payer source?

4. *Affirmative efforts to improve health quality for racially identifiable groups*: With the emphasis today on health care quality improvement and dissemination, should agencies and entities that receive federal funding be

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141. These are the standards that determine whether an entity can enter a health care market at all (e.g., conditions of participation for Medicare-participating hospitals, nursing facilities, managed care organizations, home health entities, and other providers).

required to demonstrate that they pursue quality improvement activities aimed at enhancing provider performance in the case of racially and culturally distinct subgroups of patients, particularly in the area of clinical decision-making practices? Should they be required to incorporate into their quality improvement strategies policies that reduce administrative and linguistic barriers to care and enhance patients' knowledge of their rights and roles in the care process?

5. *Health professions training programs*: Should recipients of federal health professions training grants and awards be expected to demonstrate evidence of active recruitment of minority candidates?<sup>142</sup> Should they be required to show that their curriculum includes efforts to increase the ability of health professionals to engage in appropriate treatment practices for patients who are members of racial and ethnic minorities?

6. *Biomedical research*: Should grantees have to demonstrate affirmative efforts to design clinical and other trials that test the impact of interventions on members of distinct racial and ethnic minority groups? Should recipients have to demonstrate an affirmative effort to include members of racial and ethnic minority groups in clinical trials?

By considering these questions and beginning to articulate clearer performance goals in a health context, and by inter-weaving Title VI compliance into federal program participation and grant administration standards, we believe three advantages could be gained. The first relates to eliminating distinctions between program compliance and civil rights compliance. The constitutional basis for Title VI (the Spending Clause) means that an entity cannot participate in a federal program if it is not in compliance with Title VI. By integrating the two sets of compliance requirements (program compliance and civil rights compliance), the government would erase the false distinction—and the ensuing confusion—that has arisen over the past three decades and would make it easier for the recipients of federal financial assistance to understand what is expected of them.

The second reason to incorporate Title VI standards into general program standards speaks to a basic reality that underlies the modern effort to achieve racial equality in health care. Because of the demographics of poverty, it is, as a practical matter, difficult to separate conduct with an adverse impact on the poor and publicly insured from racial discrimination. Incorporating Title VI compliance and health program participation standards would obviate the need to distinguish between income and race discrimination and allow federal agencies to

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142. See UNEQUAL TREATMENT, *supra* note 15, app. B.

focus instead on layered reforms that do not parse the problem to a non-remediable point.

To appreciate the third advantage of incorporating Title VI compliance into general program standards, one must consider the gravity of a charge of racism. It is evident to those who are familiar with civil rights efforts that there is no more painful conversation than one involving race discrimination. Given the history and ugliness of racial discrimination in health care, the topic is an electrifying one, and an accusation of racism is especially painful in light of the strong fiduciary tradition that imbues health professionals with the notion that they act solely in the interest of their patients. The notion of "doing the right thing" is so basic to health care that when the system is accused of not doing the right thing, the results are extremely distressing.

We believe that by merging the legal basis of federal health care standards to encompass both program performance and civil rights compliance, the federal government could do much to transform the discussion to one that is grounded in both quality and equality and to simultaneously minimize the temptation to classify activities as programmatic or racial in nature. Given the nexus between race and income, federal standards that are grounded in both sets of concerns—i.e., program quality and racial equality—would be easier to grasp and accept. Merged standards also would eliminate the pressure to distinguish between race and income, at least on a prospective basis. Obviously, a legal action alleging that a recipient of federal financial assistance violated Title VI would continue to have to satisfy the elements of the claim, including the ability to show a nexus between the conduct that is complained of and a racially identifiable group. But our concern here is for prospective standards that move the system forward, not for facilitating legal actions.

In general, it no longer makes sense to divide the world of enforcement when the overall goal is the systemic improvement of program performance. Regulations built on two sets of laws—one tied to racial equality and the other to program performance and health quality—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. By establishing both racial equality and program quality improvement as two inextricably linked goals (a direction that finds strong support in the IOM study),<sup>143</sup> the federal government would immeasurably strengthen its hand in the setting of prospective standards of conduct. The

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143. *Id.*

final step in a federal effort to move systematically on issues of civil rights enforcement is compliance measurement. Clearly, if the government is to set standards that are meant in part to reflect racial equality goals, it must have a method for measuring compliance. Whether this is done through routine program reporting, specialized studies and surveys, periodic self-assessments of performance against a set of negotiated benchmarks, or some other means, there must be a way of measuring results and reporting on them. A whole industry that has grown up around benchmarking, performance measurement, performance reporting, and performance dissemination offers insights into the tools available for this type of compliance effort. If the federal government and other health purchasers can insist on accountability in health quality on the part of hospitals, nursing homes, and even physicians in private practice, then it is difficult to see why measures of racial justice in performance are any more controversial. To be sure, there are an enormous number of technical issues that arise in the development of a racial classification and reporting system,<sup>144</sup> but these technical difficulties are no reason not to develop the most feasible approach possible under technical constraints.

We have no illusion that upgrading federal involvement in civil rights enforcement will be free.<sup>145</sup> At the same time, the cost to the system of unequal treatment is vast, as the IOM has demonstrated.<sup>146</sup> Had the *Sandoval* case not been decided in the way that it was, we could perhaps continue to imagine that private actions are adequate to remedy the

144. For example, how would physician network accessibility be measured? How would the government implement reforms aimed at making sure hospitals receiving graduate medical education payments modified their practices to come into compliance with federal regulations?

145. Nor would we agree, however, with the argument that health care financing is a zero-sum game, such that resources directed toward new civil rights enforcement efforts in health care would somehow draw on existing health care expenditures. Indeed, the country has seemed quite willing over the past couple of decades to accept rather dramatic spending increases in health care. According to the federal government, national health expenditures have increased almost six-fold since 1980. See Ctrs. for Medicare and Medicaid Services, National Health Expenditure Table 1, *available at* <http://www.cms.hhs.gov/statistics/nhe/historical/t1.asp> (last visited May 29, 2002). This trend appears likely to continue, for example, in the form of a new prescription drug program for Medicare beneficiaries. We would also argue that it is not clear that additional enforcement efforts would drive up health care costs in real terms, since in the long run efforts associated with increased access to care might actually reduce overall costs to the health system.

146. See generally UNEQUAL TREATMENT, *supra* note 15.

problem of discrimination in health care. But *Sandoval* has put that delusion to rest once and for all, and now the only remaining question is whether the federal government will meet the challenge that has been thrust upon it.