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Title VI and Health Facilities: Forms Without Substance

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Its (the 1970 report of the U.S. Commission on Civil Rights) basic conclusion was that the great promise of civil rights laws had not been realized, that the federal government had not yet fully prepared itself to carry out the civil rights mandate. . . .

. . . The Federal response has been . . . with a few significant exceptions, a continuation of tentative first steps towards more stringent civil rights enforcement and promises of better performance in the future.[1]

Introduction

Title VI of the Civil Rights Act of 1964,[2] which prohibits racial discrimination by recipients of federal funds, is part of one of the most controversial and important pieces of legislation in American history. Title VI was enacted primarily to prohibit segregation in publicly-funded schools, but it applies to all recipients of federal funds, including institutions that provide health care.[3]

In the fourteen years since the 1964 legislation, Title VI enforcement in the field of education has generated much political controversy and has had a far reaching impact on the nation's educational institutions.[4] The impact of Title VI enforcement on health facilities, however, is much more difficult to assess. The major controversy gen-

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1. U.S. COMMISSION ON CIVIL RIGHTS, FEDERAL CIVIL RIGHTS ENFORCEMENT EFFORT—SEVEN MONTHS LATER 3 (1971).

2. Civil Rights Act of 1964, Pub. L. No. 88-352, tit. VI, §§ 601-605, 78 Stat. 252-53 (codified at 42 U.S.C. §§ 2000d-2000d-4 (1970)). The 1964 Act is summarized at text accompanying notes 50-53 *infra*.

3. For a discussion of the application of Title VI to individual physicians receiving federal funds, see notes 72 & 193 *infra*.

4. *See generally* III UNITED STATES COMMISSION ON CIVIL RIGHTS, THE FEDERAL

erated in this area has revolved around the government's attempts to establish a meaningful monitoring and enforcement program rather than around actual attempts to eliminate the widespread racial discrimination which exists in the health-facility context.[5] Civil-rights groups, including the United States Commission on Civil Rights, have frequently criticized the federal government's efforts as ineffective and inadequate.[6] Even the government officials charged with responsibility for administering the Title VI enforcement program have generally agreed that the program has been less than successful in monitoring health-facility compliance, although these officials usually cite a lack of resources and staff as the primary reason for this failure.[7] It is also likely that most administrators of health facilities subject to Title VI are dissatisfied with a program that very often adds to their paperwork yet infrequently deals with matters of substantial importance.

For a health facility to comply with Title VI usually requires only that the facility sign a nondiscrimination agreement,[8] one of many forms appended to the lengthy, government fund applications that facilities must execute but need not take seriously. Compliance with Title VI can and should mean much more to a health facility.

Achieving racial equality through the enforcement of civil rights is an important national policy. The country is currently going through a historically unprecedented examination of both the delivery of health

CIVIL RIGHTS ENFORCEMENT EFFORT—1974 (1975) [hereinafter cited as ENFORCEMENT EFFORT—1974].

5. See notes 96-173 & accompanying text *infra*.

6. *See, e.g.*, VI ENFORCEMENT EFFORT—1974, *supra* note 4 at 109-209. The United States Commission on Civil Rights was established in 1957. 42 U.S.C. § 1975 (1970 & Supp. V 1975). The Commission was established primarily to monitor and investigate civil rights violations, but it has served as a watchdog over the government's efforts to enforce civil rights. The periodic reports of the Commission are one of the primary sources of empirical data used in this Article. The quality of the reports varies greatly; although some are excellent, others contain sloppy work such as demonstrating a lack of awareness of previous Commission reports. Frequently, the Department of Health, Education, and Welfare (HEW) and the Office of Civil Rights (OCR) have taken issue with the conclusions in the reports. An attempt has been made in this Article to use the reports selectively and to cite parallel sources when available.

7. *See Hearings on J. Stanley Pottinger to be Assistant Attorney General, Civil Rights Division Before the Senate Comm. on the Judiciary*, 93rd Cong., 1st Sess. (1973); *Hearings on Title VI Enforcement in Medicare and Medicaid Programs Before the Subcomm. on Civil Rights and Constitutional Rights of the House Comm. on the Judiciary*, 93rd Cong., 1st Sess. 128-84 (1973) (testimony of Peter Holmes) [hereinafter cited as *1973 Hearings*]; HEW, NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS, PROPOSED ANNUAL OPERATING PLAN FOR FY 1978, 42 Fed. Reg. 39,823 (1977).

8. See text accompanying note 75 *infra*.

services as a whole and of its constituent institutions.[9] Serious changes are likely, although it is difficult to predict their exact nature.[10] However, the role of the institutional provider of health services will remain central to the health care delivery system. It is also likely that the majority of health facilities will remain privately owned and administered, a situation which distinguishes the American system from those other industrialized countries.[11] Whatever system emerges, health facilities must be held accountable to the society for ensuring that its services are available to all regardless of race.

Although the basic scheme of government-funded, privately-administered health facilities will continue to underlie the health-care delivery system, government control, or at least scrutiny, of these facilities is likely to increase. It is in this context that the issue of racial discrimination in the delivery of health services must be confronted directly.

9. Significant issues have been raised regarding the quality and distribution of health care that Americans receive. Some critics argue that too high a proportion of the health-care dollar is spent on curative medical care, rather than on less expensive and more effective methods of preventive medicine. *See generally* I. ILLICH, LIMITS TO MEDICINE (1976); J. KNOWLES, DOING BETTER AND FEELING WORSE (1977); G. ROSEN, PREVENTIVE MEDICINE IN THE UNITED STATES 1900-1975 (1977). Increases in health care costs dramatize another aspect of the crisis. Since 1965, the overall cost of health care has grown at an annual rate of 12%, exceeding the rate of inflation for the rest of the economy. In that time, the cost of hospital care and physician services has quadrupled and tripled, respectively. *See* SOCIAL SECURITY BULL., April 1977, at 12. The nation's health bill has risen from $38.9 billion in 1965, to almost $140 billion in 1976, representing a proportional rise in the GNP from 5.9% to 8.6%. *Id.* at 4. Projections for 1980 anticipate continued increases to levels over $230 billion and 9%. PUBLIC HEALTH SERVICE, HEW, FORWARD PLAN FOR HEALTH 1978-82, at 30 (1976).

10. Congress is currently examining several national health insurance proposals. *See, e.g.*, H.R. 760, 95th Cong., 1st Sess. (1977). The Carter administration has advocated mandatory limitations on increases in health facilities' costs. H.R. REP. No. 6575, S. REP. No. 1391, 95th Cong., 1st Sess., 1977). A variety of mandatory and regulatory controls are being imposed at both the state and the federal levels. *See, e.g.*, The National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k-t (Supp. V 1975), which officially recognized the magnitude of the problem of providing equal access to quality healthcare at a reasonable cost. The purpose of the Act is to further the development of state and federal health care programs by providing staff power, facilities, and financial assistance. Recently there has even been a serious proposal by The American Public Health Association for a nationalized health service. *Public Health Unit Presses for "National Health Service,"* Washington Post, Nov. 4, 1977, at A2.

11. Of 7,156 hospitals in the country in 1975, 382 were federal, 2,306 were state and local government operated, 3,562 were private nonprofit, and 906 were investor owned (for profit). Most large hospitals are private, nonprofit institutions, and the vast majority of general, acute-care hospital beds are in such institutions. COMPARATIVE STATISTICS ON HEALTH FACILITIES AND POPULATION 25 (American Hospital Association 1977). No industrial country other than the United States depends on private facilities for most of its health care. *See* Abel-Smith, *Major Patterns of Financing and Organization of Medical Care in Countries Other than the United States*, in SOCIAL POLICY FOR HEALTH CARE 25 (1969).

The general problem of access to health-care services, and the specific problem of inequitable treatment of racial minorities, will be important in any governmental decisions to increase regulation or to reallocate resources. This is particularly true because the increased costs of health care have made the denial of adequate care a growing reality for more people. The enforcement of Title VI will exemplify the government's ability and willingness to regulate health-care providers and to impose public policy on ostensibly private institutions.

It must be noted at the outset of this Article that the nature and extent of the problem of racial discrimination in health facilities is difficult to define with specificity. It is generally known that prior to 1964 many health facilities maintained open policies of racial segregation or explicitly excluded minorities. There is also fairly convincing proof that since 1964 these policies have been eliminated. Does discrimination continue despite the elimination of these policies? If so, in what form? Because of the inadequate manner in which the Title VI enforcement program has been administered, there is little monitoring of health facility compliance and virtually no available data generated on the services delivered to minorities. What evidence exists must be derived from collateral sources.

The evidence that is available, as will be explained in greater detail in Part V of this Article, indicates that substantial inequities continue to exist. There are significant patterns of segregation in the delivery of institutionally-based health services.[12] In addition, racial minorities are significantly underserved by the nation's health facilities despite indications that minorities have a greater need for health services.[13]

The question is whether these inequities constitute racial discrimination in the legal sense of the term and, if so, whether they can be legally attributable to particular health facilities. Even a cursory examination of the complicated arrangements through which patients are referred to health facilities and receive treatment suggests a number of difficult legal issues that must be addressed before these questions can be answered.[14] Unfortunately, because of poor data collection, we are not yet at a point when these issues can be directly addressed. The attempts to enforce Title VI have not only failed to isolate the key issues or contribute to their resolution, they have failed even to describe adequately the general outlines of the problem. What little is known

12. See text accompanying notes 179-80 *infra*.
13. See text accompanying notes 181-84 *infra*.
14. See text accompanying notes 193-98 *infra*.

about the nature and extent of racial discrimination in health facilities is disturbing. The fact that so little is known is itself cause for concern.

As a consequence of this lack of data, this Article does not focus on substantive issues. Rather, this Article attempts to document the relevant legislative and political history of Title VI as it relates to health facilities, to detail the implementation of the enforcement program, and to assess the current status of both the enforcement program and the problem that it is trying to resolve. Ways will be suggested in which the agencies involved can better meet the goals of Title VI.

Parts I and II describe the problem of racial discrimination in health facilities prior to 1964 and the relevance of this problem to the passage of the Civil Rights Act of 1964. What little has been written relating racial discrimination in health facilities to the enactment of Title VI has not always been entirely accurate. In particular, inferences concerning health facilities drawn from the legislative history of Title VI must be carefully construed because of the unusual course the bill followed through Congress, the drastic changes that occurred in the bill at various points, and the incredible range of problems that were being considered at that time. When the difficult substantive issues of applying Title VI to health facilities are finally addressed, this history will have an important role in the final determination of the intent and meaning of this potentially far-reaching legislation.

Parts III and IV describe the initial implementation of the Title VI health-facilities enforcement program during the period following the enactment of Medicaid and Medicare, and the eventual development of a complex, administrative program that relies predominantly on complaint investigation and the monitoring of enforcement activities by state health agencies to assure compliance with Title VI. Few people actually understand the complicated arrangements between the state health agencies and HEW, and there is considerable evidence that when these arrangements have become final, they are not being carried out in an effective manner. It is this inadequate attempt to develop a realistic enforcement program that is largely responsible for the failure of HEW adequately to define the problem or to contribute to its resolution.

Part V is a description of what is known about the problem of racial discrimination in health facilities and the impact of Title VI enforcement. It includes a description of recent litigation which clearly illustrates some of the problems of racial discrimination in today's health facilities. It is this litigation that may force HEW to improve its enforcement program and eventually confront the real substantive is-

sues. Part VI suggests changes in the administration of Title VI that could improve the enforcement program. The goal of this Article is to lay the foundation for an understanding of the history and current status of Title VI enforcement in health facilities and to contribute to the resolution of a problem that continues to plague our nation.

Federal Policy Prior to the Civil Rights Act of 1964

Prior to the enactment of Title VI, federal agencies made token efforts to adopt policies prohibiting racial discrimination in programs or activities receiving federal funds.[15] There is little indication, however, that these few exceptional policies were ever vigorously enforced. They clearly were not representative of an overall federal commitment to prohibit discrimination by recipients of federal funds or to use federal funding as leverage to achieve a national policy of racial equality. The legislative history of Title VI[16] indicates that most federal agencies were unwilling or felt themselves unable to prohibit discrimination without a specific, legislative authority or mandate.[17] Most agencies,

15. The United States Commission on Civil Rights claims, without providing a list, that prior to 1964 several federal agencies adopted funding policies prohibiting racial discrimination although they had no explicit authority to do so. UNITED STATES COMMISSION ON CIVIL RIGHTS, CIVIL RIGHTS UNDER FEDERAL PROGRAMS: AN ANALYSIS OF TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, at 7 (1968). In addition, executive orders had banned racial discrimination in the armed services, Exec. Order No. 9,981, 3 C.F.R. 722 (1943-48 Comp.) (revoked by Exec. Order No. 11,051, 3 C.F.R. 635 (1959-63 Comp.)); in employment by federal government contractors, Exec. Order No. 10,479, 3 C.F.R. 961 (1949-53 Comp.) (revoked by Exec. Order No. 10,925, 3 C.F.R. 448 (1958-63 Comp.)); and in federally supported housing, Exec. Order No. 11,063, 3 C.F.R. 652 (1959-63 Comp.). There was, however, no explicit statutory authority. See note 17 *infra*.

16. *Hearings on Miscellaneous Proposals Regarding the Civil Rights of Persons Within the Jurisdiction of the United States Before Subcomm. No. 5 of the House Comm. on the Judiciary*, 88th Cong., 1st Sess. pts. II, III, IV (1963) [hereinafter cited as *1963 Hearings*]. The hearing record is in four parts. Part I includes the text of the 167 different bills that were submitted to the House during the Spring of 1963. Parts II and III include the testimony of 101 witnesses, 70 prepared statements, and 22 written communications with the subcommittee. Part IV is actually labeled *Hearings on H.R. 7152* and is a transcript of the executive session of the full Committee on the Judiciary that occurred after the subcommittee reported the first version of the final civil-rights bill. Because of the unusual legislative procedures that were to follow, see notes 40-51 & accompanying text *infra*, this was the only committee to hold full hearings on the 1964 civil rights legislation.

17. Whether there was inherent or implied executive authority to prohibit discrimination was a much debated issue prior to the enactment of Title VI. Early in 1963, the United States Civil Rights Commission urged President Kennedy either to require such a policy of all federal agencies or to seek the authority to do so. *See* UNITED STATES COMMISSION ON CIVIL RIGHTS, REPORT OF THE UNITED STATES COMMISSION ON CIVIL RIGHTS (1963), *summarized at* 110 CONG. REC. 6994-7001 (1964). President Kennedy publicly expressed doubts as to whether he had the power to prohibit discrimination absent legislative authority. *See* Comment, *Title VI of the Civil Rights Act of 1964: Implementation and Impact*, 36

therefore, continued to fund health, education, and social-welfare programs without regard to the recipients' policies on racial discrimination, even when the funding recipient was openly segregated.[18]

The history of the Hill-Burton, health-facilities construction program,[19] which was the major health-related, federal-funding program[20] between 1946 and 1965, is a good illustration of the pre-1964 attitude of most federal agencies towards discrimination practiced by recipients of federal funds. The Hill-Burton program was enacted for the purpose of eliminating what was then perceived to be the major problem in health care in this country, a shortage of beds in hospitals and other health facilities.[21] Federal funds were made available to states that instituted a survey of their need for health facilities, developed a plan

GEO. WASH. L. REV. 824, 827 n.14 (1968) [hereinafter cited as Comment]. He eagerly took credit, however, for the actions of those agencies that assumed such authority. *See* CIVIL RIGHTS AND JOB OPPORTUNITIES—MESSAGE FROM THE PRESIDENT OF THE UNITED STATES, H.R. DOC. NO. 124, 88th Cong., 1st Sess. (1963), *cited in full at* 109 CONG. REC. 11174 (1963), in which President Kennedy outlines the accomplishments of the agencies discussed at note 15 *supra*.

The concept of inherent or implied executive authority is important despite the enactment of Title VI because the issue may still arise in two contexts. First, a state official might attempt to use a general state-licensing statute to prohibit discriminatory action by licensed bodies. See note 105 & accompanying text *infra*. Second, a federal agency may choose to take steps to ensure affirmative action beyond those required by Title VI.

Convincing arguments can be made that the executive may prohibit discrimination by recipients of state or federal funds without explicit statutory authority to do so. As a general proposition, absent an explicit, congressional requirement or prohibition, the federal executive is free to contract on any terms or conditions it may find appropriate. Arizona v. California, 373 U.S. 546, 580 (1963); Kern-Limerick, Inc. v. Scurlock, 347 U.S. 110, 116 (1954). Federal or state funding of private or public operations can certainly be characterized as contractual in nature. Furthermore, any congressional requirement or prohibition in a health or welfare program that prevented the executive from curtailing discriminatory practices would probably be void as illegal discrimination itself.

It can also be argued that a prohibition on racial discrimination by recipients of funds is not only permitted but required if the government funding represents sufficient involvement with the funded activity to constitute state action. *See* Simkins v. Moses H. Cone Memorial Hosp., 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964), discussed at notes 28-30 & accompanying text *infra*.

18. A few federal programs were specifically authorized to provide financial assistance to segregated institutions. *See, e.g.*, Morrill Act, 7 U.S.C. § 323 (1976) (aid to agricultural and mechanical, "A & M," colleges) (apparently still in effect); Hill-Burton Act, 42 U.S.C. § 291 (1970 & Supp. V 1975) (aid for construction of health facilities). For a discussion of the Hill-Burton Act, see notes 19-33 & accompanying text *infra*.

19. 42 U.S.C. § 291 (1970 & Supp. V 1975).

20. The Hill-Burton program was the first major federal investment in the health-care delivery system. It has been estimated that nearly half the hospitals in the country have received Hill-Burton funds since 1946. Rose, *The Hill-Burton Act—The Interim Regulation and Service to the Poor: A Study in Public Interest Litigation*, 6 CLEARINGHOUSE REV. 309 (1972).

21. *See* 42 U.S.C. § 291(a) (1970) (statement of legislative purpose).

to meet those needs, and maintained a system of licensing that would ensure a minimum standard of facility quality and safety.[22] Public and nonprofit, private institutions that could show a need for expanded facilities under the state plan applied through the state for federal construction funds.

Receipt of Hill-Burton funds, in the form of direct grants, loans or loan guarantees, required little from the facility beyond an assurance that it would provide a reasonable volume of care to people who were unable to pay and that it would be available to all persons in the serviced area without regard to race, creed, or color.[23] This assurance was not required, however, if "equitable provision for separate population groups," was made by the recipient facility.[24] There was, in effect, a statutory "separate but equal" exception to the nondiscrimination requirement. From 1946 to 1963, 70 out of nearly 7,000 recipients of Hill-Burton funding qualified under this exception.[25] All other Hill-Burton recipients executed an assurance of nondiscrimination, but many of them continued to engage in disparate practices based on racial critieria.

This situation was due in large part to HEW's rather limited view of what constituted discrimination.[26] According to HEW policy, a facility that did not qualify for the exception could not deny a person admission on the basis of race to that part of the facility constructed with Hill-Burton funds; admission could still be denied to those parts of the same facility that were not constructed with the federal-program funds. While no patient in the facility could be denied "essential services," patients could be segregated within a facility and individual medical practitioners could be denied privileges or employment on the basis of their race.

22. *Id.* Prior to 1946 and the incentives of the Hill-Burton program, many states did not license hospitals. *See generally* A. SOMERS, HOSPITAL REGULATION: THE DILEMMA OF PUBLIC POLICY (1969). See also note 105 *infra*.

23. Hospital Survey and Construction Act of 1946, ch. 958, § 2, 60 Stat. 1041 (repealed 1964).

24. *Id.*; 42 C.F.R. § 53.112 (1956) (repealed 1964).

25. UNITED STATES COMMISSION ON CIVIL RIGHTS, EQUAL OPPORTUNITY IN HOSPITALS AND HEALTH FACILITIES: CIVIL RIGHTS POLICIES UNDER THE HILL-BURTON PROGRAM (1965) [hereinafter cited as EQUAL OPPORTUNITY IN HOSPITALS]. See text accompanying notes 179 & 192 *infra*.

26. EQUAL OPPORTUNITY IN HOSPITALS, *supra* note 25, at 6, citing the opinion of HEW General Counsel interpreting 45 C.F.R. § 112 (revised later, see note 31 *infra*) as it applied to facilities receiving funds prior to *Simkins*.

In 1963, in *Simkins v. Moses H. Cone Memorial Hospital*,[27] a group of black physicians, dentists, and patients brought suit against two Greensboro, North Carolina, hospitals that had received Hill-Burton funds under the "separate but equal" exception.[28] The plaintiffs alleged that the defendant hospitals' refusal to grant staff privileges to black practitioners and to admit black patients[29] discriminated against them in violation of their rights to equal protection under the fourteenth amendment. The Court of Appeals for the Fourth Circuit held that the Hill-Burton program and the receipt of Hill-Burton funds by the hospitals constituted state action[30] and declared the separate-but-equal exception unconstitutional.

In response to *Simkins*, HEW issued new Hill-Burton regulations,[31] specifying that the requirement of nondiscrimination meant

27. 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964). The district court opinion in this case is found at 211 F. Supp. 628 (M.D.N.C. 1962).

28. Both facilities named as defendants had received sizeable Hill-Burton grants. Cone Hospital received $462,000 in 1954 and $807,950 in 1960, which amounted to approximately 15% of the total construction costs of the two projects. Wesley Long Community Hospital received a grant of $1,617,150 in 1959 and grants of $66,000 and $265,000 in 1961, which amounted to approximately 50% of the cost of the projects. 323 F.2d at 963. In each case, HEW approved funding applications that stated that the "requirement of non-discrimination has been met because this is an area where separate hospital facilities are provided for separate population groups." 211 F. Supp. at 633.

29. Moses H. Cone Memorial Hospital had a policy of denying staff privileges to black practitioners and admitted black patients only under limited circumstances. Wesley Long Community Hospital also had a policy of denying privileges to black practitioners and admitted no black patients.

30. 323 F.2d at 967 (quoting the standard enunciated in Burton v. Wilmington Parking Auth., 365 U.S. 715, 724 (1961)). It should be noted that the Supreme Court later indicated that state involvement with a private institution that has a policy of discrimination must be directly related to that policy in order for there to be state action. Moose Lodge No. 107 v. Irvis, 407 U.S. 163 (1972) (state issued liquor license to club that refused service to blacks). Note, however, the qualitative difference between liquor licensing and health-facility licensing. *See also* Jackson v. Metropolitan Edison Co., 419 U.S. 345 (1974). Both *Moose Lodge* and *Jackson* seem to indicate the Court's unwillingness to expand state action to the extent suggested in *Burton* and followed in *Simkins*.

The Fourth Circuit, however, continues to find state action in Hill-Burton participation alone. *See, e.g.*, Doe v. Charleston Area Medical Center, Inc., 529 F.2d 638 (4th Cir. 1975). For a good analysis of the Fourth Circuit cases as well as other bases for judicial review of the policies of private hospitals, see Note, *Judicial Review of Private Hospital Activities*, 75 MICH. L. REV. 445 (1976). Although the broader, state-action implication of *Simkins* has not been followed in most other circuits, it is a generally recognized authority with regard to race discrimination by health facilities. *See* Briscoe v. Bock, 540 F.2d 392 (8th Cir. 1976); Doe v. Bellin Memorial Hosp., 479 F.2d 756 (7th Cir. 1973); Ward v. St. Anthony Hosp., 476 F.2d 671 (10th Cir. 1973); Eaton v. Grubbs, 329 F.2d 710 (4th Cir. 1964).

31. 29 Fed. Reg. 6,497 (1964). When Congress renewed the Hill-Burton program in 1964, it omitted both the nondiscrimination requirement and the separate but equal provision from the statute. Pub. L. No. 88-443, § 603(a), 78 Stat. 451 (1964). Later, a broader

that practitioners could not be denied privileges on the basis of race, color, or creed; patients could not be segregated within an institution; and discrimination in admission would be prohibited in all sections of a facility constructed in whole or in part with Hill-Burton funds. HEW's general counsel, however, took the position that these regulations were applicable only to pending applications and future Hill-Burton recipients.[32] Even after Title VI of the Civil Rights Act of 1964 and its implementing regulations clearly prohibited these types of discrimination, HEW persisted in holding the position that Hill-Burton recipients receiving funds prior to January 4, 1965, the effective date of the new regulations, were bound only by the original narrow definition of discrimination.[33] It was not until the implementation of Medicare and Medicaid, which brought almost all hospitals and nursing homes within the purview of the Title VI regulations, that discrimination in these health facilities was effectively prohibited.

"community service" requirement was added in its place obligating recipients of Hill-Burton funds to make their services available to all persons residing in the area. 42 U.S.C. § 291c(e) (1970). In December 1964, new Hill-Burton regulations were issued, amending the nondiscrimination requirement to apply only to discrimination based on creed and including language drawing attention to Title VI of the Civil Rights Act of 1964 and its Title VI regulations (to be issued shortly thereafter). 42 C.F.R. 53.111-.112 (1964). The current Hill-Burton regulations continue to use the following language (although the sections have been rearranged several times):

> (a) Before an application is recommended by a state agency to the Secretary for approval, the state agency shall obtain an assurance from the applicant that all portions and services of the entire facility for the construction or modernization of which, or in connection with which, aid under the Act is sought will be made available without discrimination on account of creed and no professionally qualified person will be discriminated against on account of creed with respect to the privilege of professional practice in the facility.
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> . . . .
>
> (c) Attention is called to the requirement of Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d; 78 Stat. 252) which provides that no person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefit of, or be subjected to discrimination under any program or activity receiving federal financial assistance. A regulation implementing such Title VI, applicable to assistance under this part of or construction and modernization of hospitals and medical facilities, has been issued by the secretary of Health, Education, and Welfare with the approval of the President.

Arguably, race discrimination is now a violation of the community-service requirement, 42 U.S.C. § 291c(e) (1970); 42 C.F.R. § 53.113 (1976), as well as a violation of Title VI, despite the 1964 change in the regulations.

32. EQUAL OPPORTUNITY IN HOSPITALS, *supra* note 25, at 7.

33. *Id.* at 9. *See also* 110 CONG. REC. 1527 (1964) (remarks of Rep. Celler indicating that Title VI would not be applied retroactively).

The Enactment of the Civil Rights Act of 1964

It would be futile to try to isolate all of the key historical and political factors that led to the enactment of the Civil Rights Act of 1964. Several factors, however, are undeniably important and particularly relevant to a consideration of Title VI.

In the decade following *Brown v. Board of Education*,[34] it became increasingly obvious that reliance solely on traditional remedies or judicial intervention was not an effective means of eliminating discrimination. The courts proved unable to fashion suitable remedies to deal with institutionalized discrimination, and, in some cases, state and local governments were prepared to defy court orders.[35] During the same period it became clear that, despite a few isolated, executive actions, there was no clearly-defined, federal policy either regarding the affirmative steps that the executive should take to enforce the law or, as *Simkins* demonstrated, regarding the limits of direct or indirect, governmental involvement with discriminatory, private action.

The political climate of this period was reflected in the fact that both major political parties made the enactment of new civil-rights legislation part of their 1960 national platform.[36] Yet by the spring of 1963 President Kennedy, despite public commitments to do so, had neither secured nor even proposed new legislation.

In June 1963, with racial violence flaring in several parts of the country, Kennedy sent a special message[37] to both houses of Congress urging them to remain in session until a comprehensive, civil-rights bill could be passed.[38]

34. 347 U.S. 483 (1954).

35. *See* Dunn, *Title VI, the Guidelines and School Desegregation in the South*, 53 VA. L. REV. 42 (1967); *Developments in the Law—Section 1983 and Federalism*, 90 HARV. L. REV. 1133 (1977); EQUAL OPPORTUNITY IN HOSPITALS, *supra* note 25; 110 CONG. REC. 1517 (1964) (remarks of Rep. Celler).

36. Both platforms are cited at 110 CONG. REC. 1511-12 (1964).

37. CIVIL RIGHTS AND JOB OPPORTUNITIES—MESSAGE FROM THE PRESIDENT OF THE UNITED STATES, H.R. DOC. NO. 124, 88th Cong., 1st Sess. (1963).

38. Civil-rights legislation had been proposed earlier in the session. The first civil-rights bill, submitted in January of 1963, was introduced by the ranking minority member of the House Committee on the Judiciary. H.R. 3139, 88th Cong., 1st Sess. (1963). The bill was described by the author as comprehensive, but moderate. 109 CONG. REC. 1538 (1963). The bill would have made permanent the U.S. Civil Rights Commission, protected voting rights in federal elections, limited literacy tests for voting, offered financial assistance to schools attempting to desegregate, and required equal-opportunity employment in government-sponsored employment contracts. At least 172 similar bills were submitted by various members of Congress throughout the following spring dealing with all or some of the same issues. *See* H.R. REP. NO. 914, 88th Cong., 2d Sess. 17 (1964).

The entire Republican, minority membership of the Committee submitted identical

In the Senate Kennedy's[39] proposed legislation was referred to committee but was never reported back to the floor.[40] In the House[41] extensive hearings were held by a subcommittee of the Committee on

bills the same day. The Republican strategy was apparently to upstage the Democratic administration and embarrass the President for failing to follow through on his campaign promises. *See* 109 CONG. REC. 1560 (1963) (remarks of Rep. Lindsay).

The first Democratic bill was introduced on the President's behalf by Congressman Celler on April 4, 1963. H.R. 5455, 5456, 88th Cong., 1st Sess. (1963); *see* 109 CONG. REC. 5832 (1963). *See also* H.R. DOC. NO. 75, 88th Cong., 1st Sess. (1963), *reprinted in* 109 CONG. REC. 3245 (1963), President Kennedy's first, moderately-toned message to Congress submitted to the House of Representatives on February 28, 1963. This first Kennedy proposal was an unremarkable bill extending the life of the Civil Rights Commission and making several minor proposals for amendment of existing civil-rights legislation; it did not include a Title VI type provision.

39. H.R. 7152, S. 1731, 88th Cong., 1st Sess. (1963). For text of the bill, see 109 CONG. REC. 11077 (1963). The President's new bill went far beyond his first proposal by including additional provisions prohibiting discrimination in public accommodations, giving the Attorney General the authority to initiate suits against segregated school systems, establishing an equal-employment-opportunity commission, and prohibiting discrimination in federally-funded programs. The bill included the following: Title I: protection of voting rights; Title II: injunctive relief against discrimination in public accommodations; Title III: desegregation of public education; Title IV: establishment of a community relations service; Title V: extension of the U.S. Commission on Civil Rights; Title VI: prohibition of discrimination in federal programs; Title VII: creation of an equal-employment commission. *Cf.* note 50 *infra* (final bill).

40. Senate Majority Leader Mansfield submitted the President's bill. S. 1731, 88th Cong., 1st Sess. (1963). Later that same day Mansfield submitted S. 1750, a bill jointly sponsored by the minority leader Sen. Dirksen, which contained a somewhat smaller range of provisions. *See* 109 CONG. REC. 11083 (1963). Among other things the jointly-sponsored bill lacked provisions relating to employment discrimination which were contained in Title VII of the President's bill. See note 39 *supra*.

Senator Mansfield also submitted S. 1732 on behalf of himself and Senator Magnuson; the bill concerned discrimination in public accommodations and essentially corresponded to Title II of the President's bill. S. 1732 was referred to the Committee on Commerce of which Magnuson was chairman, 109 CONG. REC. 11083 (1963), and it was the only Senate bill to clear committee, see note 45 *infra*, and therefore the report on S. 1732 is cited as part of the official legislative history of the Civil Rights Act of 1964 even though it is only tangentially related to it. *See* S. REP. NO. 872, 88th Cong., 2nd Sess., *reprinted in* [1964] U.S. CODE CONG. & AD. NEWS 2355.

41. Representative Celler submitted the President's proposed bill, H.R. 7152, to the House. The legislative history of that version of the bill is particularly important because the hearings held on H.R. 7152 were the only substantive hearings held on the Civil Rights Act of 1964. For an explanation of these hearings, see note 16 *supra* & note 42 *infra*. The Senate never held Committee hearings, but note that the version of H.R. 7152 finally sent back to the House from the Committee was a last-minute draft that revised H.R. 7152. Also note that the Senate substantially amended the House bill, see text accompanying note 47 *infra*, and again rewrote the bill just prior to passage. Thus the legislative history consists only of the floor debates, the procedural machinations, and the House hearings on H.R. 7152. In order to attribute any legislative history to any given part of the bill, one must trace that provision through the several versions of the legislation to determine whether that provision was in the then-pending bill and, if so, in what form.

the Judiciary which then went beyond Kennedy's proposal and reported to the whole Committee a more extensive version of a civil-rights bill.[42] The Committee, however, managed to moderate that proposal[43] and the bill that eventually passed the House was similar in form and content to the original Kennedy proposal.[44]

After lengthy political maneuvering, the House bill was heard in the Senate without reference to a committee.[45] After an eighty-seven

42. The hearings were held from May 8 to August 2, 1963. See note 16 *infra*. *See also* H.R. REP. NO. 914, 88th Cong., 1st Sess., *reprinted in* [1964] U.S. CODE CONG. & AD. NEWS 2391. For a description of those hearings (22 days, 101 witnesses) from the viewpoint of an opponent of the legislation, see "Additional Views of Hon. George Meader," *id.* at 2412. The Subcommittee also met in executive session August 14-31. *Id.* at 2413. The bill was finally reported on October 2.

43. Attorney General Robert Kennedy appeared before an executive session of the Committee and argued that for both pragmatic and constitutional reasons, the Subcommittee's bill went too far. Kennedy urged the Committee to rewrite the bill in keeping with the President's original proposal. *1963 Hearings, supra* note 16, pt. IV. Note that the testimony is actually before the whole Committee but is included in the Subcommittee transcript. Attorney General Kennedy testified that the bill should be rewritten by the Subcommittee in the following respects. First, he urged that the voting rights in Title I be limited to federal elections because he was not convinced that there was constitutional power to regulate state elections. Second, he opposed on constitutional grounds the extension of Title II from public accommodations in the strict sense to all businesses licensed by state or local government. Third, he argued that the injunctive power of the new Title III (missing from the President's bill) should be limited to racial matters, rather than all constitutional rights. Ironically, many of these objections were directed at provisions that ultimately were included in the Civil Rights Act of 1964.

44. On October 29, 1963, after several weeks of debate, Celler produced a 56 page substitute draft. Several members of the Committee were later to complain that they had seen Celler's new draft for the first time only hours before the Committee met; some claimed not to have read it at all. Debate on the new draft was limited to two minutes—one for the Chairperson and one for the ranking Republican on the Committee. Both spoke in favor of the draft. This form of the bill is analyzed in H.R. REP. NO. 914, 88th Cong., 1st Sess., *reprinted in* [1964] U.S. CODE CONG. & AD. NEWS 2393-2409. But see note 43 *supra*.

Amended in this hasty manner, the new H.R. 7152 was reported out of Committee and eventually to the floor of the House on January 30, 1964. After a lively but relatively short debate, H.R. 7152 was passed by the House on February 10, 1964. H.R. REP. NO. 1119, 88th Cong., 2d Sess. (1964); (report from Rules Committee) 110 CONG. REC. 1511 (1964). It has been reported that the Rules Committee reported the bill under the threat of a discharge petition. *See* Comment, *supra* note 17, at 831.

45. Because of the domination of Senate committees by political conservatives it was unlikely that the House Bill would have survived reference to a committee. The two Mansfield bills had died in Committee during the first session of the 88th Congress. See note 40 & accompanying text *supra*. Thus, when the bill was read for the first time, Senator Mansfield proposed the unusual step of considering H.R. 7152 without reference to a committee, a procedure which had been used rarely since the inception of the committee system in 1948. 110 CONG. REC. 2882 (1964). The acting President Pro Tem of the Senate, Senator Metcalf, accepted the proposal, *id.* at 2886, whereupon it was debated by the Senate and upheld by a narrow margin, *id.* at 6416.

day floor debate, the longest in the history of the Senate,[46] and last minute redrafting of several, important provisions, the bill passed the Senate on June 19, 1964.[47] After acceptance of the Senate version by the House,[48] it was signed into law by President Johnson on July 2, 1964.[49]

The final version of the Civil Rights Act of 1964,[50] including Title

46. Throughout the debate conservative senators tried to limit the scope and purpose of the bill by a continuous series of amendments and finally tried to kill it by a filibuster. *See* 110 CONG. REC. 14443 (1964) (remarks of Sen. Humphrey).

On June 10, 1964, a cloture rule was proposed and carried by a vote of 71-29. 110 CONG. REC. 13327 (1964).

47. 110 CONG. REC. 14511 (1964). The Senate vote was 73-27. By the time the debate had ended, more than 500 amendments had been proposed. 110 CONG. REC. 15895-96 (1964). The version of H.R. 7152 finally enacted, however, was a compromise "eleventh-hour" draft written by Senators Humphrey, Dirksen, and Kuchel. The final version incorporated some of the amendments but also moderated many of the provisions, particularly those which related to enforcement activities. For an explanation of the compromise, see 110 CONG. REC. 12706 (1964) (remarks of Senator Humphrey). Among other things, the compromise added the employment exception and several provisions clarifying the procedures to be followed in making determinations of compliance with Title VI. But in general, Title VI as originally proposed by President Kennedy remained intact. *See* 110 CONG. REC. 15896 (remarks of Rep. Celler).

48. When the Senate's version of the bill was returned to the House, it was referred to the Committee on Rules. For a good summary of the major issues involved in this legislation and of the legislative history of the bill, see *Hearings Before the Committee on Rules on H.R. Res. 789*, 88th Cong., 2d Sess. (1964).

A one-day hearing was held, and a one-sentence resolution was reported to the floor. *Providing for the concurrence of the House of Representatives to the Senate Amendment to H.R. 7152*, H.R. REP. NO. 1527, Committee on Rules, 88th Cong., 2nd Sess. (1964). Note that the chairperson of the committee chose not to sign the report because of his personal opposition to the bill. After a brief debate, the House accepted the Senate bill, 289-126. 110 CONG. REC. 15897 (1964).

49. Pub. L. No. 88-352, 78 Stat. 241 (see note 50 for codification).

50. Title I (expansion and protection of voting rights in both state and federal elections), Pub. L. No. 88-352, 78 Stat. 241 (codified at 42 U.S.C. § 1971 (1970)); Title II (prohibition of discrimination in public accommodations and authorization of injunctive action by a private party or the Attorney General), Pub. L. No. 88-352, 78 Stat. 243 (codified at 42 U.S.C. § 2000a (1970)); Title III (authorization for independent action by Attorney General after petition by private party complaining of discrimination in public facilities other than educational institutions), Pub. L. No. 88-352, 78 Stat. 246 (codified at 42 U.S.C. § 2000b (1970)); Title IV (technical assistance and grants to assist in desegregation; authorization of suits by Attorney General to enforce rights to education), Pub. L. No. 88-352, 78 Stat. 246 (codified at 42 U.S.C. §§ 2000c-2000c-9 (1970)); Title V (extension of the U.S. Civil Rights Commission), Pub. L. No. 88-352, 78 Stat. 249 (codified at 42 U.S.C. §§ 1975a-1975d (1970)); Title VI, Pub. L. No. 88-352, 78 Stat. 252 (codified at 42 U.S.C. §§ 2000d-2000d-4 (1970)); Title VII (establishment of the Equal Employment Opportunity Commission and the substantive standards defining employment discrimination), Pub. L. No. 88-352, 78 Stat. 253 (codified at 42 U.S.C. §§ 2000e-2000e-15 (1970)); Title VIII (requirement for the Secretary of Commerce to compile registration and voting statistics), Pub. L. No. 88-352, 78 Stat. 266 (codified at 42 U.S.C. § 2000f (1970)); Title IX (procedures after removal of civil-rights

VI, followed the basic scheme of the bills originally filed by President Kennedy, Representative Celler, and Senator Mansfield.[51] Section 601 of the act enacted the substantive policy of Title VI: "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."[52]

Section 602 imposed several limitations on the enforcement of Title VI, but also provided the primary statutory authority for administrative action to enforce the policy of nondiscrimination enunciated in Section 601:

> Each Federal department and agency which is empowered to extend Federal financial assistance to any program or activity, by way of grant, loan, or contract other than a contract of insurance or guaranty is authorized and directed to effectuate the provisions of section 601 with respect to such program or activity by issuing rules, regulations, or orders of general applicability which shall be consistent with achievements of the objectives of the statute authorizing the financial assistance in connection with which the action is taken . . . . Compliance with any requirement adopted pursuant to this section may be effected (1) by the termination of or refusal to grant or to continue assistance under such program or activity to any recipient as to whom there has been an express finding on the record, after opportunity for hearing, of a failure to comply with such requirement, . . . or (2) by any other means authorized by law . . . .[53]

suits from state court to federal court; authorization of Attorney General to intervene in civil-rights suits), Pub. L. No. 88-352, 78 Stat. 266 (codified at 28 U.S.C. § 1447 (1970)); Title X (establishment of community relations service), Pub. L. No. 88-352, 78 Stat. 267 (codified at 42 U.S.C. §§ 2000g-2000g-3 (1970)); Title XI (trial by jury in criminal contempt proceedings brought under the law; clarification of validity of state laws covering same subjects; other miscellaneous provisions), Pub. L. No. 88-352, 78 Stat. 268 (codified at 42 U.S.C. §§ 2000h-2000h-6 (1970)).

51. See notes 38-41 & accompanying text *supra*.

52. Pub. L. No. 88-352, tit. VI, § 601, 78 Stat. 252 (codified at 42 U.S.C. § 2000d (1970)).

53. Pub. L. No. 88-352, tit. VI, § 602, 78 Stat. 252 (codified at 42 U.S.C. § 2000d-1 (1970)). *See also* Pub. L. No. 88-352, tit. VI, § 603, 78 Stat. 252 (codified at 42 U.S.C. § 2000d-2 (1970)) (establishing judicial review of administrative decisions made under this authority); Pub. L. No. 88-352, tit. VI, § 604, 78 Stat. 252 (codified at 42 U.S.C. § 2000d-3 (1970)) (prohibiting the exercise of authority under Title VI over employment practices); Pub. L. No. 88-352, tit. VI, § 605, 78 Stat. 252 (codified at 42 U.S.C. § 2000d-4 (1970)) (apparently eliminating from the scope of Title VI any recipient of federal funds by way of contract of insurance or guaranty); Pub. L. No. 88-352, tit. VI, § 602, 78 Stat. 252 (codified at 42 U.S.C. § 2000d-1 (1970)) (requirements relating to voluntary compliance; requirement that all rules, regulations, and orders be cleared by the President; and requirement of notice to the Senate and House prior to fund termination of any recipient).

It is readily apparent that the provision of the House bill, and its predecessors that later became Title VI, was not the sole cause of the extended controversy over the enactment of the Civil Rights Act. Legislators argued more over those provisions that prohibited discrimination in public accommodations, enforced voting rights in both federal and state elections, and prohibited discrimination in employment. In fact, many of the original bills did not include a Title-VI-type scheme. Prohibitions of racial discrimination in federally funded activities or programs appeared for the first time in President Kennedy's own bill and in his June 1963 message to Congress.[54] One commentator has even reported that the Kennedy administration considered the Title VI provision a "throw in": something that could be compromised in order to gain support for the rest of the bill.[55] Whatever its original purpose, and whoever really supported the idea, once the Title VI provision appeared in the Kennedy proposal, it was included in some form in all subsequent bills, somehow managing to weather the storm for which it was only partially responsible.

It is even more apparent that eliminating discrimination in the delivery of health services was not a primary objective of Title VI or any of the other provisions of the Civil Rights Act. To the extent that two years of debate can be characterized and the discussion of Title VI provisions can be separated from other issues, the major hope of proponents, and the principle concern of opponents, concerned the use of Title VI as an administrative tool to deal effectively with the problem of school segregation in areas where state and local government had been uncooperative and the courts ineffective.

Notwithstanding this lesser concern with discrimination in health services, it is absolutely clear that in both the strict legal sense and the broad descriptive sense, Congress intended Title VI to prohibit racial discrimination in *all* federally funded programs and activities, including those for health services. At all points in the legislative process, references were made to prohibiting discrimination throughout the entire spectrum of federally funded activities with frequent references to health services, particularly hospital services.[56]

54. See notes 37 & 39 *supra*.

55. Comment, *supra* note 17, at 831.

56. *See 1963 Hearings, supra* note 16, at 1830-46 (statement of Dr. Walter J. Lear, Medical Committee for Human Rights), 2485 (written statement of American Public Health Association), 2776-77 (letter from Assistant Attorney General Katzenbach to Chairman Celler enumerating federal programs to be effected by Title VI); H.R. REP. No. 914, 88th Cong., 2nd Sess., *reprinted in* [1964] U.S. CODE CONG. & AD. NEWS 2453, 2472, 2511 (statement of dissent by Republican minority); 110 CONG. REC. 1538 (1964) (remarks of Rep. Rodino on

At the time that the final act was passed, no one could have anticipated the 1965 enactments of the Medicaid and Medicare programs and the resultant, massive federal involvement in health care that was to characterize the late 1960's and early 1970's. Even in 1964, however, the federal financial involvement in health services was already substantial, growing annually, and involving many, though not all, health facilities.[57] *Simkins* had publicized the problem of discrimination in Hill-Burton facilities, and the finding of discrimination in that case showed the potential impact of the Title VI concept on the nation's hospital system.[58] Congress was also aware that many health facilities received federal funds as vendors of services under the Kerr-Mills program,[59] a limited, welfare-related, health-services program that was the forerunner to Medicaid.

In short, Title VI and its applications were considered at length but not in depth. Title VI was the result of a long, hard-fought battle, but a battle in which political expediency continually predominated over the need for full consideration of the details of the proposals. Such expediency is understandable when one considers that any further attempt to study or consider the bills would probably have degenerated into the kind of rhetorical, overly broad, policy dispute that typified the two years of debate.

As a result, it is very difficult to rely on legislative history to determine what many of the specific provisions of the Act were intended to authorize. In the literal sense the legislative history is fairly straightforward. It is clear that the 88th Congress intended Title VI to establish a policy of nondiscrimination and to authorize an administrative program to enforce that policy. The intent to extend that policy and program to health facilities is quite clear, notwithstanding the lesser

the day the House received the committee report on H.R. 7152); 110 CONG. REC. 8622 (1964) (remarks of Sen. Sparkman during the Senate floor debate).

57. On Feb. 10, 1964, the same day that the House passed H.R. 7152, President Johnson's "Health Message" was introduced into the House record. HEALTH MESSAGE FROM THE PRESIDENT OF THE UNITED STATES, H.R. DOC. NO. 224, 88th Cong., 2d Sess. (1964), *reprinted in* 110 CONG. REC. 2805-09 (1964). The message reported that the federal health budget for 1964-65 was $5.4 billion, having doubled in eight years, and that the total health expenditures for the nation in 1964 had been $34 billion, which was six percent of the GNP. The President proposed a program of health insurance for the aged (later to be called Medicare) and an expansion of federal health spending to fund such diverse programs as health-personnel education and mental-retardation and mental-health services. If made a decade later, such requests would have seemed ridiculously inadequate. See notes 9 & 10 *supra*.

58. Remedying the "separate but equal" language of the type declared unconstitutional in *Simkins* was one reason given in support of Title VI. 110 CONG. REC. 1658 (1964).

59. Social Security Amendments of 1960, Pub. L. No. 86-778, tit. VI, 74 Stat. 924 (1960) (amended 1965).

role those facilities played in the deliberations. The history of the origin of Title VI and the debate during its enactment, however, give little guidance either as to the kinds of discriminatory practices that are prohibited or the methods of enforcement that are authorized. Apparently, few legislators actually considered Title VI's impact on health services beyond the ending of segregation in hospitals and nursing homes. Little knowledge existed of the various discriminatory practices incident to segregation or of the proper methods to ensure nondiscrimination in health facilities. Nonetheless, Congress clearly gave HEW a broad, albeit undefined, mandate to prohibit discrimination. After 1964, HEW attempted to apply that mandate to the variety of programs it funded, including those that financed the delivery of health services—a field that was on the eve of an unprecedented period of growth and change.

Initial Enforcement Efforts

With uncharacteristic speed HEW issued the first set of regulations implementing Title VI in January 1965.[60] The regulations interpreted the applicability of Title VI;[61] defined discrimination in terms of specific activities, going far beyond the narrow concept of discrimination of the pre-1964 Hill-Burton program;[62] described the assurances that

60. 30 Fed. Reg. 35 (1965). Those initial HEW regulations were drafted by a special interagency committee which included representatives from the Department of Justice and the Bureau of the Budget. The HEW regulations were used as the model for the Title VI regulations of other agencies. *See* UNITED STATES COMMISSION ON CIVIL RIGHTS, HEW AND TITLE VI, A REPORT ON THE DEVELOPMENT OF THE ORGANIZATION, POLICIES AND COMPLIANCE PROCEDURES OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, at 6 (1970) [hereinafter cited as HEW AND TITLE VI]. With some technical amendments, the substantive requirements of the regulations stayed the same until the amendments of 38 Fed. Reg. 17,978 (1973).

Although HEW proceeded immediately with some Title VI enforcement activities, President Johnson's original budget request for supplemental funds to cover expenditures for the fiscal year that had already started was for $13,088,000. Of this $8,000,000 was for Title IV enforcement (education); no funding was requested for Title VI enforcement. H.R. DOC. No. 318, 88th Cong., 2d Sess. (1964).

61. 45 C.F.R. § 80.2 (1976) makes these regulations applicable to all recipients of federal funds. 45 C.F.R. § 80.2(a), however, excludes contracts of insurance or guaranty, as required by 42 U.S.C. § 2000d-1 (1970), which may be relevant to recipient health facilities. Although the section has been interpreted not to exclude Hill-Burton loan guarantees, *see* 45 C.F.R. § 80, Appendix A, pt. 2, No. 22, the issue of applicability may be raised when the 1974 revisions to the Hill-Burton program are implemented. Under the new program, loans and guarantees may be made directly to recipients, instead of through the states. 42 U.S.C.A. § 300 (1974-1977 Supp.).

62. 45 C.F.R. § 80.3 (1976) defines prohibited actions in noninclusive terms. In practice those definitions, which apply to a variety of health, education, and welfare programs,

must be executed by recipients of federal funds;[63] and set out procedures for enforcement and monitoring of compliance by recipients.[64]

The regulations were, of necessity, generalized in form and applicable to the whole range of health, education, and welfare programs funded by HEW.[65] Several statutory provisions were interpreted as they applied to specific situations (*e.g.*, "in the case of institutions of higher education"),[66] but in general both the substantive and procedural requirements were not specifically interpreted.[67] Consequently, the regulations invested HEW officials with broad authority that paralleled the mandate of Title VI but they gave little guidance to officials in terms of the application of this authority to specific programs.[68]

In the decade that followed, the major HEW enforcement efforts under these regulations were directed toward applying Title VI to programs that provided funding to elementary and secondary schools.[69] The beginning of the Title VI enforcement program, however, practically coincided with the enactment of Medicare and Medicaid; thus,

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have not been specific enough, and HEW has had to issue interpretive guidelines applying the regulations to specific institutions. See note 68 *infra*.

63. 45 C.F.R. § 80.4 (1976). Note also the applicability of the assurance to the entire recipient institution, 45 C.F.R. §§ 80.4(d), 80.5(e), 80.8(c), as contrasted with previous HEW policy under the Hill-Burton program. See text accompanying notes 32 & 33 *supra*.

64. 45 C.F.R. § 80.6-.11 (1977).

65. 45 C.F.R. § 80.2 (1977). Appendix A is a list of programs to which these regulations apply, but it is noninclusive.

66. The specific provisions tend to anticipate the application of these regulations to educational institutions, as have subsequent amendments. *See* 38 Fed. Reg. 17,982 (1973).

67. See text accompanying notes 191-98 *infra*.

68. In 1966, HEW issued guidelines interpreting the applicability of the substantive regulations to nursing homes and hospitals. OCR, HEW, GUIDELINES FOR COMPLIANCE OF NURSING HOMES AND SIMILAR FACILITIES WITH TITLE VI FOR THE CIVIL RIGHTS ACT OF 1964 (issued in revised form November 1969); GUIDELINES FOR COMPLIANCE OF HOSPITALS WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 (issued in revised form November 1969). It is difficult to define the legal status of those documents because they are not issued through formal rulemaking which would be governed by the procedural requirements of 42 U.S.C. § 2000d-1 (1974). At the least, they are OCR's official interpretation of the application of Title VI to these facilities.

69. The enforcement of Title VI in elementary and secondary school systems has been at the forefront of Title VI activity and controversy since its passage. Initially, education activities and health related enforcement activities were handled by different offices within HEW. It was only with the consolidation of all HEW Title VI activities into one office, see text accompanying notes 97-101 *infra*, that the health facility enforcement program was directly competing for resources with elementary and secondary education. The issue of priority within HEW as a whole, however, was never in doubt. Elementary and secondary education enforcement activity was not only the top priority, many civil rights staff felt it was the only priority. *See* HEW AND TITLE VI, *supra* note 60, at 33-38.

For a discussion of the early education enforcement efforts, *see* UNITED STATES COMMISSION ON CIVIL RIGHTS, SOUTHERN SCHOOL DESEGREGATION, 1966-67 (1967).

HEW was faced immediately with the need to apply the Title VI regulations to programs that made nearly all hospitals and nursing homes recipients of federal funds.

Unlike the Hill-Burton program, which had defined the "problem with health care" as a shortage of available facilities,[70] Medicare[71] was enacted in recognition of the inability of many people, particularly the elderly, to afford needed medical care.[72] Under the scheme outlined in the federal statute and the initial Medicare regulations, a hospital or a skilled nursing home must be certified by HEW as having met certain "conditions of participation,"[73] must sign an acceptable provider agree-

70. See text accompanying note 21 *supra*.

71. 42 U.S.C. § 1395-1395pp (1970 & Supp. V 1975). For background on the enactment of Medicare and its initial implementation, see H. SOMERS & A. SOMERS, MEDICARE AND THE HOSPITALS: ISSUES AND PROSPECTS (1967) [hereinafter cited as SOMERS]. For the best legal analysis of the program, see Butler, *An Advocate's Guide to the Medicare Program*, 8 CLEARINGHOUSE REV. 831 (1975); Butler, *Medicare Appeals Procedures: A Constitutional Analysis*, 70 NW. U.L. REV. 139 (1975). For a reference on the programming details, see MEDICARE AND MEDICAID GUIDE (CCH) (1968).

72. S. REP. NO. 404, 89th Cong., 1st Sess., *reprinted in* [1965] U.S. CODE CONG. & AD. NEWS 1946. *See also* SOMERS, *supra* note 71, at 6. Medicare is a federally financed and administered, health-insurance program for social security recipients. Medicare Part A, 42 U.S.C. § 1395c-1395i (1970), which automatically covers all eligible recipients, pays primarily for hospital and skilled nursing home services, 42 U.S.C. § 1395d (1970). There are several levels of nursing home care and several definitions of those levels which have been used throughout the history of the Medicare and Medicaid programs. See notes 80 & 114 *infra*. Medicare Part B, which is optional on the payment of a small monthly premium, primarily covers physician services, and certain supplementary benefits. 42 U.S.C. § 1395j (1970).

HEW officials have generally taken the position that private physicians who are participating providers under Medicare are not covered by Title VI, apparently on the theory that there is no contractual agreement between the government and the individual physician. SOCIAL SECURITY ADMINISTRATION, HEW, CLAIMS MANUAL, ch. X, § 10.069 (May 1970) (revised June 1972). See VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 118-19 for a discussion of this interpretation of the law and indication that OCR is reconsidering its position.

Peter Holmes, Director of OCR from April 1973 until Spring 1977, testified in 1973 that physicians participating in Medicaid were within the scope of Title VI, but physicians participating in Medicare were not. *1973 Hearings, supra* note 7, at 177. This is an extremely questionable interpretation of the law.

Part A and Part B taken together pay for only a portion of the cost of the "covered" services. A Medicare recipient has substantial deductible and co-insurance obligations and may be liable to the provider for the difference between the provider's charge and the amount of Medicare reimbursement. Medicare also has substantial limitations in the kind of services covered and the duration of coverage. For details see Butler, *An Advocate's Guide to the Medicare Program*, 8 CLEARINGHOUSE REV. 831, 833-35 (1975).

73. The substantive standards are set forth for each category of institutional provider in the Medicare regulations. 20 C.F.R. § 405.1011-1416 (1977). See discusssion of current process of certification at text accompanying notes 105-24.

ment relating to reimbursement arrangements,[74] and must execute a nondiscrimination assurance and a facility compliance report.[75] Until it fulfills these conditions, no facility may receive reimbursement for services provided to eligible Medicare beneficiaries.

At the same time Medicare was enacted, although with somewhat less political fanfare,[76] Congress enacted the Medicaid program under which federal funds were made available to those states that chose to provide a health-benefits program to the poor—primarily welfare recipients.[77] In order to participate in the program, a state must meet

74. Social Security Administration, HEW, Form SSA-1561. The agreements are basically a summary of the facility's obligations with respect to noncovered services, collecting deductibles, and co-insurance. If HEW finds a facility to be in noncompliance with Title VI, HEW must presumably go through the termination-of-funding procedures outlined in the Title VI regulations, 45 C.F.R. §§ 80.1-.11 (1976), subject to the procedures for judicial review at 42 U.S.C. § 1316 (Supp. V 1975). *See* Gardner v. Alabama, 385 F.2d 804, 811 (5th Cir. 1967), *cert. denied*, 389 U.S. 1046 (1968). Compliance with Title VI, however, is a substantive requirement for the initial certification of a hospital or a skilled nursing facility. 20 C.F.R. § 405.1501(d) (1977). *But see* 20 C.F.R. § 405.1901(e) (1977).

The Medicaid regulations make no explicit reference to Title VI. However, because hospitals and skilled nursing facilities must meet the Medicare requirements in order to be certified for Medicaid, the language cited above would consequently apply to Medicaid participants. With respect to intermediate-care facilities, there is no explicit reference to Title VI in the Medicare regulations or cross reference to it in the Medicare regulations. It could still be argued that Title VI compliance is a substantive requirement for certification of those facilities, because the Title VI assurance is one of the documents executed by intermediate care facilities as part of the certification agreement.

75. In addition to the basic statement of assurance that all institutions had to sign, HEW 441 (PHS 12/64), compliance report forms were developed for each category of institutional provider: for hospitals, Medical Facilities Compliance Report (Civil Rights Act Title VI), PHS-4867 (2-66), and for skilled nursing homes, Extended Care Facilities (ECF) Compliance Report (Civil Rights Act Title VI), PHS-4888 (4-66). Those forms requested statements of policy and data on patients currently in the facility in an attempt to document Title VI compliance. It is important to note that HEW uses compliance reports only as part of the initial Medicare certification process and for facilities which are first-time recipients of federal funds. Medicare facilities are not required to submit the reports on a regular basis. See text accompanying notes 105-25 *infra* for a discussion of Medicare certification procedures after the initial phase. Some Medicaid facilities, however, are periodically reviewed. See text accompanying note 121 *infra*.

The original forms were revised several times. HEW currently uses Hospital Compliance Report, OS/CR 501; and Compliance Report for Extended Care Facilities, Nursing Homes, and Other 24 Hour Facilities, OS/CR 502.

76. Medicaid has been described as the "sleeper" provision of the Medicare-Medicaid legislation because it was a rather brief amendment added to the Medicare bill at a time when Congress appeared to be more interested in enacting a health-care program for the elderly. *See* Stevens & Stevens, *Medicaid: Anatomy of a Dilemma*, 35 LAW AND CONTEMP. PROB. 348, 348 (1970).

77. 42 U.S.C. §§ 1396-1396i (1970). For a good legal analysis of the Medicaid program, see Butler, *The Medicaid Program: Current Statutory Requirement and Judicial*

certain federal requirements[78] and offer a minimum range of services, including hospital and nursing-home services.[79]

Unlike Medicare, the federal Medicaid law as initially enacted left the selection of health providers primarily to the discretion of each participating state.[80] HEW, therefore, first concentrated its Title VI enforcement efforts on the initial certification of Medicare institutions, leaving enforcement within Medicaid facilities to the states. Only later, as part of its review of state-agency compliance activities, did HEW indirectly review Medicaid-provider institutions.[81] As a practical matter, most hospitals and many nursing homes were already under the direct review of HEW at this time because most facilities that participated in Medicaid also participated in Medicare.[82]

Medicare was scheduled to go into effect on "M" day, July 1, 1966, one year after its enactment.[83] On that date HEW was faced with the prospect of administering a program that would reimburse nearly 20,000 health facilities for the variety of services to be provided to 19,000,000 eligible beneficiaries. Special rules and procedures had to be devised for special types of providers. Financial arrangements had to be made with a whole variety of institutions.[84] Ultimately, seventeen different, detailed manuals of standards were developed, each corresponding to a different category of participant. Understandably, the

Interpretations, 8 CLEARINGHOUSE REV. 7 (1974). For the best general reference on the program, see MEDICARE AND MEDICAID GUIDE (CCH) (1968).

78. 42 U.S.C. §§ 1396a, 1396d (1970 & Supp. V 1975).

79. 42 U.S.C. § 1396a(a)(13)(B) (1970 & Supp. V 1975). See notes 80 and 114 *infra* for a discussion of levels of nursing homes.

80. The original federal statute was quite general in defining the standards which the states had to apply in allowing hospitals and nursing homes to participate in Medicaid. The initial federal regulations, however, required hospitals participating in Medicaid to meet Medicare standards. 42 C.F.R. § 449.10(b)(1) (1977) (originally enacted in 1968).

The nursing homes participating in Medicaid were defined differently than under Medicare, and the standards which they had to meet were primarily left to each state. In 1972, Congress amended the federal statute to consolidate the standards for nursing homes under Medicaid and Medicare, explicitly requiring Medicaid skilled nursing facilities (the new consolidated term) to meet the same standards as Medicare skilled nursing facilities (with some minor exceptions). 42 U.S.C. § 1396d(i) (1974). See also note 114 *infra*.

The states still take primary responsibility for deciding which facilities can participate in Medicaid and some vestiges of the dual standards remain even though the standards are in fact the same. This is one cause of the confusion that often defeats attempts at Title VI enforcement.

81. See text accompanying notes 126-48 *infra*.

82. The major exceptions were levels of nursing homes that were not covered by Medicare but could be covered by Medicaid programs. See note 114 *infra*.

83. For an account of the political climate, see SOMERS, *supra* note 71, at 1-24.

84. *Id.* at 28.

complicated process of provider certification, including the review of the Title VI assurance forms and facility reports, pushed the HEW bureaucracy to the brink of chaos and encouraged expedient actions and compromise.[85] The Office of Equal Health Opportunity (OEHO) was created within the Public Health Service and was given the responsibility of reviewing the executed assurances and reports.[86] HEW attempted, in only a few short weeks, to train a special staff of officers to identify compliance problems and conduct on-site reviews of noncomplying facilities.[87] Their success was questionable. The United States Commission on Civil Rights, reviewing OEHO performance during that initial period, sharply criticized the staff's training and

85. *Id.* at 87. *See also* HEW AND TITLE VI, *supra* note 60, at 44-47.

86. HEW AND TITLE VI, *supra* note 60, at 44; Comment, *supra* note 17, at 981. Although the Public Health Service was assigned responsibility for the Medicare certification process, most of the administrative control for the program was exercised by the Bureau of Health Insurance, Social Security Administration, which was replaced when the Health Care Financing Administration was formed within HEW in 1977.

In an attempt to coordinate Title VI efforts among various federal agencies during the initial stages of implementation, the Department of Justice developed "coordination plans" which outline procedures for monitoring and enforcement of programs receiving federal funds from more than one federal agency. Under those plans, HEW was delegated responsibility for Title VI monitoring and enforcement activities for educational institutions and for health facilities funded by some 21 agencies. HEW had the responsibility for Title VI compliance activities up to the point of formal enforcement action and was required to maintain a list of all institutions which executed a Title VI agreement. Another responsibility was the periodic publishing of reports to up-date the list and to indicate noncomplying facilities. VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 690-98. An example of the original agreement delegating authority to HEW for enforcing Title VI compliance can be found at 32 Fed. Reg. 2823 (1967). For the periodic reports on compliance activities and the compliance status of institutions, see HEW, STATUS OF TITLE VI COMPLIANCE, INTERAGENCY REPORT (published periodically).

Although the interagency agreements make sense, the orientation towards the type of recipient rather than the type of program funding can cause problems and even apparent contradictions when a particular program dictates preferential treatment of minorities, *e.g.*, a clinic for migrant workers or native Americans. The HEW forms require an assurance of nondiscrimination from a facility without any delineation of the exact Title VI responsibilities of the recipient when the funding received *requires* the recipient to make direct or indirect racial distinctions.

87. A staff of nearly 500 people was hastily assembled, including several hundred people temporarily assigned from other HEW programs, medical students who were on summer internships, and a number of outside consultants. After a three week "crash" civil-rights training program, this staff spent the summer that followed reviewing the compliance reports submitted by participating hospitals. By the end of the year, nearly 7,000 hospitals had been reviewed, and 4,000 on-site visits had taken place. By the fall of 1966, most of the temporary and summer staff were no longer available. That is of crucial significance to the initial Medicare certification of nursing homes, because after the review of hospitals a significantly smaller OEHO had to certify and do Title VI reviews of nursing homes. Nursing home decisions, therefore, were based almost entirely on the assurances and compliance reports, and few site visits were involved. HEW AND TITLE VI, *supra* note 60, at 44-45.

performance.[88]

Of over 4,000 hospitals actually visited by HEW during 1966,[89] all but a few were cleared for participation in Medicare after brief negotiations. Although a few were noticed for hearing and twelve were actually found ineligible for federal funds, all but two were subsequently reinstated.[90] HEW later claimed that as a result of Title VI enforcement during the initial phases of the Medicare program, nearly all of the nation's hospitals were committed to a policy of nondiscrimination.[91] That statement was probably true in only the sense that such policies were adopted, not that they were followed.

By the time HEW shifted its focus from hospitals to nursing homes, the fledgling OHEO had developed formidable staffing problems. Consequently, the nursing homes entering the Medicare program received an even more cursory certification.[92]

Many hospitals and nursing homes that signed the assurances were later found to be in violation of Title VI. They had either openly maintained policies of direct segregation, or they had continued less overt but equally discriminatory practices, such as denial of access to special services.[93] There is little doubt that as a result of Title VI, and the financial incentives of Medicare reimbursement, many health facilities admitted their first minority patient in the summer of 1966. The result of this effort was to require the execution of the assurances, not to require full compliance with Title VI itself.

In addition, many health facilities were allowed to participate in Medicare under exceptions to the certification requirements.[94] Some facilities opted to qualify only for the exceptions, in order to avoid

88. HEW AND TITLE VI, *supra* note 60, at 16. *See also* VI ENFORCEMENT EFFORT—1974, *supra* note 4.

89. HEW AND TITLE VI, *supra* note 60, at 46.

90. *Id.* at 47.

91. *Id.* at 46.

92. See note 81 *supra*. Only about 10% of the nursing home applicants were reviewed in any depth. HEW AND TITLE VI, *supra* note 60, at 46.

93. For examples of segregated room assignments and other "subtle" discrimination, see 1973 HEARINGS, *supra* note 7, at 41, 45-46, 49-50, 130, 289, 315. *See also* Comment, *supra* note 17, at 983-88.

For a more systematic appraisal of the extent of discrimination in those health facilities, see the results of the studies conducted by OCR in 1969, text accompanying notes 179-84 *infra*, and the GAO study of 1972-73, text accompanying notes 185-92 *infra*.

94. One exception allows emergency services to be provided by noncertified hospitals. 42 U.S.C. § 1395f(d)(1) (1970); 20 C.F.R. § 405.1011 (1977). The other exception allows noncertified facilities to provide services in areas where no other facilities are available. 42 U.S.C. § 1395x(e)(5) (1970 & Supp. V 1976); 20 C.F.R. § 405.1910 (1977).

compliance with Title VI.[95]

Ironically, that effort at the beginning of the Medicare program has been the only serious effort by HEW to monitor the compliance of all certified health facilities.

Title VI Enforcement in Health Facilities

The initial Medicare enforcement efforts were indicative of the manner in which Title VI would be enforced against health facilities in the years that followed. The responsibility for overall supervision of Title VI enforcement activities was given first to the Assistant Secretary of HEW, with each of the HEW operating agencies responsible for carrying out day-to-day enforcement within its various programs.[96] OEHO was charged with the responsibility for the initial Medicare certification and Title VI efforts.

After the first fifteen months of the Title VI program, HEW created a separate Office of Civil Rights (OCR) within the Office of the Secretary.[97] A Special Assistant to the Secretary and a small staff set overall policy, handled difficult cases, and exercised general supervision over all HEW Title VI activities, but the primary day-to-day Title VI enforcement activities remained the responsibility of the operating agencies and were coordinated by compliance officers appointed within each agency. Each of the ten regional office directors designated a special assistant for civil rights to advise the director, but to report directly to OCR.

In 1966, the House Appropriations Subcommittee directed HEW to centralize all of its Title VI enforcement responsibilities in one office.[98] Consequently, in October 1967, HEW reorganized the Title VI program[99] by dissolving such program units as OEHO and transferring many staff members of the old units to the newly expanded OCR. Each region was given a separate civil-rights office and staff to carry out enforcement programs.[100] Title VI enforcement responsibilities

95. SOMERS, *supra* note 71, at 87-88.

96. HEW AND TITLE VI, *supra* note 60, at 5. As of that time, HEW had five agencies: Public Health Service, Office of Education, Social Security Administration, Welfare Administration, and the Vocational Rehabilitation Administration. The latter two were combined into Social and Rehabilitative Services in 1967. That basic administrative configuration stayed the same until 1976. See note 103 & accompanying text *infra*.

97. HEW AND TITLE VI, *supra* note 60, at 7.

98. *Id.* at 10.

99. 32 Fed. Reg. 14,555 (1967).

100. In general, the staff of an HEW regional program reports to the regional director, not directly to its Washington counterpart. The regional OCR is a special case and has

have been consolidated in OCR ever since. The integration of Title VI responsibilities into normal program operations and the communication between OCR and the rest of the HEW bureaucracy, however, are problems that have never been fully resolved.[101]

Until recently OCR was divided into several units that carried out, for particular kinds of recipients, the various civil-rights responsibilities of OCR, including Title VI enforcement. For example, the Health and Social Services Division (HSSD) was primarily responsible for enforcing Title VI in both public and private health and welfare institutions, although the actual enforcement activities were carried out by the staff of the Health and Social Services Branch (HSSB) in each regional OCR office. In 1977, following the change in presidential administrations, OCR was once again reorganized.[102] Currently, the enforcement programs are again merged and OCR is organized in functional units rather than the former divisions concerned with specific subject areas.[103]

The staffing and funding of OCR has grown since 1968, but not at

been able to operate with a fair amount of autonomy. Regional OCR staffs make field review decisions and decide whether to refer a decision directly to the central OCR in Washington. Only the Director of OCR, however, has the authority to begin proceedings for the termination of funds or to refer matters to the Attorney General for judicial action.

101. In March, 1968, then Secretary John Gardner resigned from HEW to join the Urban Coalition. The Director of OCR, Peter Libassi, and several key staff left OCR in the next few months to join him. Gardner was succeeded by Wilbur Cohen. Cohen is reported to have implemented a policy of downgrading civil-rights enforcement on the theory that racial minorities would be better served in the long run by an overall improvement in federal health, education, and welfare programs. He even suggested that the responsibility for civil-rights enforcement be shifted to the Department of Justice. HEW AND TITLE VI, *supra* note 60, at 11. See text accompanying note 225 *infra*.

102. According to the *FY 1978 Annual Operating Plan for OCR*, OCR's responsibilities include enforcement of: (1) Title IX, Education Amendments of 1972, 20 U.S.C. § 1681 (Supp. V 1975) (sex discrimination in educational institutions); (2) Public Health Service Act §§ 799A, 855, 42 U.S.C. §§ 295h-9, 298b-2 (Supp. V 1975) (sex discrimination in professional health schools); (3) Vocational Rehabilitation Act of 1973 § 504, 29 U.S.C. § 794 (Supp. V 1975) (discrimination against disabled); (4) Age Discrimination Act of 1975, 42 U.S.C. § 6101 (Supp. V 1975) (discrimination based on age); (5) Title VII of the Education Amendments of 1972, Emergency School Aid Act, 20 U.S.C. § 1601 (Supp. V 1975) (desegregation of schools); (6) Executive Order 11246, 3 C.F.R. 339 (1964-65 Comp.) (amended by Exec. Order 11375, 3 C.F.R. 684 (1966-70 comp.) (discrimination by government contractors). HEW, NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS, PROPOSED ANNUAL OPERATING PLAN FOR FY 1978, 42 Fed. Reg. 39,823 (1977).

103. There are four functional units in OCR: Office of Administration and Management; Office of Program Review and Assistance; Office of Compliance and Enforcement; and Office of Policy, Planning, and Research. The time and resources allocated to enforcement activities concerning health facilities, at least for the present, are substantially unchanged. It remains to be seen whether this internal reorganization will result in changes in the nature or emphasis of Title VI enforcement activities.

an unusual rate.[104] The real significance of OCR staff size and budget lies in the unequal division of resources among the various OCR responsibilities: the enforcement of Title VI is strongly emphasized for elementary and secondary schools and much less emphasized for health facilities. HSSD, therefore, has always had a relatively small staff. It is largely because of the small proportion of resources allocated to health-facility enforcement programs that OCR has tended to rely on an enforcement program for health facilities that focuses on certain aspects of compliance while ignoring others.

OCR fulfills its Title VI responsibilities to health facilities primarily through four activities: (1) requiring Title VI assurances from health facilities certified for participation in the Medicare program; (2) requiring state agencies to submit Title VI compliance plans describing state enforcement activities; (3) investigating complaints and noncomplying recipients identified by assurance documentation; (4) conducting occasional special studies.

Medicare Certification and Review

The certification of health facilities for participation in Medicare and Medicaid, combined with the traditional licensing of health facilities by state agencies[105] and accreditation by a variety of private and quasi-governmental bodies,[106] has resulted in a complicated, but only

104. In 1978, OCR is budgeted for 1102 positions. 42 Fed. Reg. 39,824 (1977). The legal work, which includes handling termination hearings of the OCR, is done by the Office of General Counsel, but the staff used for this purpose is paid for out of the OCR budget.

105. Since the late 1940's, almost all states that require a facility to comply with various health and safety standards have maintained licensing programs for health facilities. Worthington & Silver, *Regulation of Quality of Care in Hospitals: The Need for Change*, 35 LAW AND CONTEMP. PROB. 305, 308 (1970). In many regards state licensing standards are similar to the federal certification standards, although the federal standards deal more directly with the quality of the services while state licensing standards traditionally have focused on fire safety and the structural adequacy of the facilities. *Id.* at 309. *See also* A. SOMERS, HOSPITAL REGULATION: THE DILEMMA OF PUBLIC POLICY (1968). Recently, however, some states have attempted to enforce standards that are more directly related to patient care, *e.g.*, patient-staff ratios.

Licensing standards and their enforcement can be coordinated with the certification of Medicaid and Medicare facilities and with their accreditation by private agencies. For example, in many states, the survey of a hospital for purposes of certification may be part of a licensing inspection, and is conducted by or in conjunction with the accreditation by the Joint Commission on the Accreditation of Hospitals (JCAH). See note 106 *infra*.

106. A number of accrediting agencies exist for a variety of purposes. For example, the American Medical Association has an accreditation program for evaluating and approving health facilities for internship and residency programs. The most important agency, however, is the Joint Commission on the Accreditation of Hospitals (JCAH) which, in addition to its role as a nationally recognized accrediting body for hospitals, has been given a signifi-

partially effective web of state and federal government monitoring and control of the quality of medical care delivered in health facilities.[107] Conspicuously absent from this web, however, is any serious affirmative effort to identify and eliminate racial discrimination in accordance with Title VI.

State agencies operating under contractual agreements with HEW make initial and periodic Medicare certification reviews which include surveying hospitals for compliance with the Medicare conditions of participation.[108] The findings of the state survey agency are then forwarded to HEW for final certification. HEW may accept hospitals accredited by the Joint Commission on the Accreditation of Hospitals (JCAH) as in compliance with the federal conditions, with some exceptions.[109] In all cases Medicare hospitals are subject to periodic surveys,

cant role in the certification process. Although lack of accreditation theoretically affects only the prestige of a facility and its standing in the eyes of its professional peers, JCAH accreditation has become tantamount to Medicare and Medicaid certification. See text accompanying note 109 *infra*. For a good history of the JCAH, see Worthington & Silver, *Regulation of Quality of Care in Hospitals: The Need for Change*, 35 LAW AND CONTEMP. PROB. 305 (1970).

107. In recent years, government control of health facilities has been extended to include a variety of attempts to control cost and distribution of health services, *e.g.*, certificate of need or rate-setting programs. At the federal level, a number of regulatory controls have been imposed on health facilities participating in Medicaid and Medicare, including controls on cost and reviews of the adequacy and quality of the services rendered under the federal programs. The Professional Standards Review Organizations (PSROs) program, 42 U.S.C. § 1320c (Supp. V 1975), which was enacted by the 1972 Social Security Amendments is probably the best example of these programs and of the way quality controls have been merged with controls on cost and capital expenditure. For a general background, see K. WING, THE LAW AND THE PUBLIC'S HEALTH (1976).

108. 42 U.S.C. § 1395aa(a) (Supp. V 1975); 20 C.F.R. § 405.1902 (1977). This must be the same agency that does the survey and evaluation of providers for participation in the Medicaid program. 42 U.S.C. § 1396a(a)(9) (Supp. V 1975). The only real difference between Medicare certification and Medicaid certification is that when a survey is done for purposes of Medicare (or Medicare and Medicaid) certification, the results are forwarded to HEW for the final certification decision. Under Medicaid, the final decision is made by the state agency that administers the Medicaid program, which may be a different agency than the one conducting the certification survey. For example, the survey may be done by the state department of public health, but Medicaid may actually be administered by the state welfare agency.

For requirements for certification, see text accompanying notes 99-102 *supra*. When a state imposes higher standards on a hospital or nursing home under the Medicaid program, HEW must use those higher standards for certification of Medicare facilities. 20 C.F.R. § 405.1901(d) (1977).

109. 42 U.S.C. § 1395bb (Supp. V 1975); 20 C.F.R. § 405.1901(b) (1977). Exceptions exist for the conditions requiring utilization review, 42 U.S.C. § 1395x(e)(6) (1970), and institutional planning, 42 U.S.C. § 1395x(z) (Supp. V 1975), because there are no comparable JCAH standards. An exception also exists for any other requirement that HEW may enact which is higher that the accreditation standards.

including extensive on-site inspections, by either JCAH or the state survey agency. They are also frequently visited by state or federal agencies which verify JCAH findings, investigate complaints, and review or identify deficiencies.

A hospital that participates in Medicaid but not Medicare is reviewed under virtually the same procedures and under the same federal conditions of participation.[110] It is subject to the same inspections, but the final decision to certify a Medicaid provider lies with the state Medicaid agency, not HEW.[111]

Not only are hospitals subject to certification and recertification survey procedures, but also they must periodically submit data concerning correction of deficiencies, results of utilization review, staffing, and other details of day-to-day operations relating to the standards of compliance to state surveying agencies. Additionally, they must submit patient-service and cost data regularly to both state and federal government agencies as part of the cost determination and reimbursement procedures.[112] Yet despite data collection, monitoring, and periodic surveys, there is no attempt to monitor hospitals on a regular basis for compliance with Title VI. Unless there is a complaint filed, a change in certification status, or another reason to investigate a particular hospital, after initial certification no attempt is made by HEW to collect any further data, monitor compliance, or validate the assurance on a regular basis, despite ample and convenient opportunities to do so.[113]

Prior to 1972, the federal statute empowering HEW to enact certification standards read: "[S]uch other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on Accreditation of Hospitals. . . ." Social Security Amendments of 1965, Pub. L. No. 89-97, § 1861(e)(8), 79 Stat. 286 (repealed 1972). HEW interpreted this provision and 42 U.S.C. § 1395bb to mean that all accredited hospitals must be certified and that HEW could impose no standards on accredited hospitals other than the exceptions listed above. The repeal of the quoted language now allows HEW to impose higher standards. The federal regulations, however, still indicate that, except for the utilization and institutional planning requirements, an accredited hospital will be certified automatically as a Medicare provider, although HEW claims the right to inspect or validate an accredited facility. 20 C.F.R § 405.1901(b) (1977).

110. Although the Medicaid statute requires only that each state establish and maintain standards for participating institutions, 42 U.S.C. § 1396a(a)(9) (Supp. V 1975), the federal regulations require Medicaid hospitals to meet the Medicare conditions of participation, 42 C.F.R. § 449.10(b)(1) (1977). Theoretically, if a facility participates in both programs, the certification decision and Title VI review are done by HEW. In practice, the division of functions is not always observed. See note 122 *infra*.

111. See note 108 *supra*.

112. *See* 42 C.F.R. § 450 (1977); 20 C.F.R. § 405.400-525 (1977). *See generally* H. MCCORMICK, MEDICARE AND MEDICAID CLAIMS AND PROCEDURES (1977).

113. Although OCR does some direct reviews of Medicare facilities, these reviews are

Nursing homes[114] are certified for participation in the Medicare and Medicaid programs in a manner similar to that described above for hospitals. There are, however, slight differences in the procedures and the standards for nursing home certification: nursing homes are generally subjected to stricter standards and closer review.[115] It is also important to note that participation in Medicare and, particularly, Medicaid is very important to nursing homes because these government programs provide such a large proportion of nursing home patients.[116]

conducted usually only in response to complaints, and the actual number of reviews is quite small. *See* VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 166-69. The rigor of those reviews, even when they are intended to be full-scale investigations, is not impressive. For example, in 1970, OCR identified the Michigan Masonic Home, a participant in the Medicare program, as open only to Masons and their wives, thus excluding blacks and other minorities. Although it is clear under OCR's interpretation of the law that this is a violation of Title VI, no enforcement proceedings were ever initiated and negotiations between OCR and the home went on for well over four years. *See id.* at 172.

114. Prior to the Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (codified in scattered sections of 5, 7, 26, 42 U.S.C.), both nursing homes and "extended care facilities" were covered under Medicaid, with separate definitions and separate requirements for participation for each, although both terms basically referred to a facility that provides continuous nursing service. In addition, "intermediate care facilities," which offer a less intensive level of care, were available under another federal welfare program, but not under Medicaid or Medicare. In 1972, amendments made "skilled nursing facilities" available under both programs and made the requirements for participation under the two programs virtually the same. It also included intermediate-care facilities as a service covered under Medicaid. *See* Pub. L. No. 92-603, § 246, 86 Stat. 1424-25 (1972) (codified at 42 U.S.C. §§ 1395x, 1396a (Supp. V 1975)); Pub. L. No. 92-603, § 278, 86 Stat. 1453-54 (1972) (codified at 42 U.S.C. §§ 1320a, 1320b, 1320b-1, 1395f, 1395x, 1395aa, 1395cc, 1395mm, 1395nn, 1396a, 1396b, 1396d, 1396h, 1396i (Supp. V 1975)). For a further discussion of the details of service coverage of Medicare and Medicaid, see sources cited in notes 71 § 77 *supra*.

115. *See* 42 C.F.R. § 449.10(b)(4) (1977); 42 C.F.R. § 450.23 (1977). For example, nursing homes are certified for a maximum of 12 months, but may be certified for even shorter periods of time where appropriate factors, such as past deficiencies, exist. 20 C.F.R. § 405.1904(b) (1977). A skilled nursing facility which participates in Medicaid but not Medicare, is surveyed by the same agency and after 1972 has had to meet the same conditions of participation as a Medicare facility in order to be certified as a Medicaid provider. Intermediate care facilities that participate in the Medicaid program are certified in a manner that is virtually identical to that of skilled nursing homes and must meet both state and federal standards.

116. The nursing home industry as it exists today was in large part created by the enactment of Medicaid and Medicare. Prior to 1964, the number of nursing homes was quite small. When Medicare and Medicaid created funding of certain categories of nursing homes, see notes 107 & 142 *infra*, they stimulated a rapid growth in the nursing home industry such that the cost of both programs due to reimbursement for nursing home services was much higher than originally anticipated. For background, see *Medicare and Medicaid: Problems, Issues, and Alternatives*, Report of the staff to the Committee on Finance, U.S. Sen., 91st Cong., 1st Sess. (1970).

As in the case of hospitals, state survey agencies, both initially and periodically thereafter, monitor those skilled nursing facilities that participate in the Medicare program for compliance with the conditions of participation. The agencies report their findings to HEW for final certification. Although a skilled nursing home may participate in Medicaid without participating in Medicare, the facility is surveyed by the same agency that surveys Medicare homes,[117] and since 1972, the Medicaid and Medicare conditions of participation have been identical.[118] All participating nursing homes are surveyed at least once a year (including an on-site inspection) and are required to submit periodic state and federal reports concerning continuing compliance with the certification standards. They must also submit the service and cost data required by the reimbursement agreements.

Since the inception of the Title VI program, state agencies administering Medicaid have been responsible for requiring that skilled nursing homes execute the initial assurance[119] and complete the initial compliance report.[120] They must also annually review each nursing home participating in Medicaid to assure compliance with Title VI,[121] although a state agency is allowed the option of negotiating a less frequent review of each facility with the regional OCR. For nursing homes participating in Medicare, the same initial Title VI forms are executed and forwarded to the state agency under contract with HEW to do certification reviews,[122] but there are no comparable annual Title

117. There is no accrediting agency comparable to the JCAH for nursing homes; therefore surveys and inspections are carried out by the state agencies either as part of the Medicaid program or under contract to HEW for Medicare. 42 U.S.C. § 1395aa (Supp. V 1975).

118. 42 U.S.C. § 1396a(a)(28) (Supp. V 1975); see note 108. The only major difference between Medicaid and Medicare certification procedures is whether the state agency or HEW has the final certification authority. Also, if a state chooses to impose higher standards for Medicaid skilled nursing homes, HEW must apply them for Medicare certification. 20 C.F.R. § 405.1901(d) (1977). Since 1970, it has been a federal requirement that all skilled nursing facilities participating in Medicaid or Medicare meet the standards of the Life Safety Code, published every three years by the National Fire Protection Association. 42 U.S.C. § 1395x(j)(13) (Supp. V 1975).

119. HEW Form 441.

120. FS-5087 (11-66) Nursing Home Compliance Report (For Use by State Agencies Administering Public Assistance Plans) (similar in substance to PHS-4888, *supra* note 75).

121. HEW State Letter 937, Nov. 17, 1966. State letters are policy statements in the form of letters to agencies administering health or welfare programs. They announce amendments to the handbook of administrative rules and guidelines, HEW Handbook of Public Assistance Administration. The handbook is distributed to those agencies and is amended periodically.

122. As with hospitals, final certification is by the Public Health Service, HEW, not by the state agency. Similarly, the regional OCR reviews the Title VI form submitted by Medicare facilities and, theoretically, by facilities applying for participation in both the

VI reviews or inspections of Medicare nursing homes unless the facilities also participate in Medicaid.[123] Although these monitoring procedures for Medicaid nursing homes represent a more vigorous attempt to ensure compliance with Title VI, there is at least some question as to whether these annual reviews have actually been carried out.[124] Furthermore, with regard to both hospitals and nursing homes, little effort has been made to use certification activities as a basis for effective enforcement of Title VI compliance.[125]

State Agency Compliance Reviews

OCR's approach to the enforcement of Title VI in health facilities has always relied on state agencies for direct monitoring activities. OCR continues to take responsibility for the initial review and monitoring of Medicare facilities, but since the initial phase of certification of Medicare providers,[126] this has required only a minimum of effort, particularly since OCR does not monitor these facilities on a regular basis.[127]

In addition to monitoring Title VI compliance of Medicaid health facilities, each state agency administering HEW-funded programs[128] must also execute a statement of compliance similar to the statement of assurance required of private recipients of HEW funds.[129] The statement of compliance must list all programs receiving federal funds, describe the methods of administration by which each agency will insure that the assurance of nondiscrimination is carried out, list the programs that are not in compliance with the Title VI requirements, and include a detailed timetable for achieving compliance.[130]

Medicaid and Medicare programs. In practice there is often confusion, and a facility may find itself being evaluated for Title VI compliance by two different agencies. State and federal officials have had problems sorting out their responsibilities with regard to facilities participating in more than one program. *See* VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 161 n.407.

123. See text accompanying note 118 *supra*.

124. See text accompanying notes 133-37 *infra*.

125. See text accompanying notes 206-11 *infra*.

126. See text accompanying notes 83-95 *supra*.

127. The number of hospitals has stabilized in recent years and there are few new providers applying for initial certification.

128. There are over 250 agencies in the various states administering these programs. The state compliance plans are supposed to include all recipients from all sources of funding and, thus, the plan developed by a state health agency could be incredibly complicated and include a vast array of individual and institutional recipients.

129. 45 C.F.R. § 80.4 (1976).

130. HEW AND TITLE VI, *supra* note 60, at 21. Obviously these documents, if completed, are enormously important to the public as well as state and federal government.

By 1968, OCR had apparently received executed assurances and some sort of compliance plan from all state agencies administering federally-funded health and welfare programs.[131] In the years following, a significant portion of the resources of OCR was devoted to a review of the adequacy of these plans, a review that even OCR admitted was not completed until recently.[132] The ostensible purpose of this review was to ensure that the methods of administration described in the plans were being implemented, but the real purpose was to determine whether the plans themselves were adequate or, in some cases, complete. From the deficiencies and problems that were encountered it is clear that this review was actually the first time that many of these documents were closely read by OCR or that the documentation and Title VI assurance were taken seriously by the state agencies.[133] Admittedly

OCR's enforcement of similar compliance plans with regard to elementary and secondary schools and institutions of higher education has generated a great deal of legal and political controversy. The enforcement of the requirements with regard to agencies administering Medicaid and other health programs has been uncontroversial. 45 C.F.R. § 80.4(c) & (d) (1976). *See* VI ENFORCEMENT EFFORT—1974, *supra* note 4; 45 C.F.R. § 80.4(d) (1976). *See also* Dunn, *Title VI, The Guidelines and School Desegregation in the South*, 53 VA. L. REV. 42 (1967).

131. Early in the program, Alabama refused to sign the assurance on the ground that it could not carry out the kind of enforcement activities required by the methods of administration or implied by the assurance. The state agency even admitted that many of the public and private institutions receiving federal funds through the state, including vendors of health services, practiced racial discrimination. In that case HEW instituted formal administrative proceedings and eventually issued an order to terminate funding. Alabama sought relief from the Court of Appeals, which upheld HEW's authority to require nondiscrimination assurances, but watered down some of the implications of Title VI. Gardner v. Alabama, 385 F.2d 804 (5th Cir. 1967), *cert. denied*, 389 U.S. 1046 (1968). *See generally Hearings Before the Senate Committee on Finance on the Proposed Cutoff of Welfare Funds to Alabama*, 90th Cong., 1st Sess. (1967).

132. Most of the initial reviews had been completed by 1971. UNITED STATES COMMISSION ON CIVIL RIGHTS, THE FEDERAL CIVIL RIGHTS ENFORCEMENT EFFORT—A REASSESSMENT 310-11 (1973) [hereinafter cited as ENFORCEMENT EFFORT—A REASSESSMENT]. By September 1974, only Hawaii and Alaska reviews were not completed. VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 153.

133. The United States Commission on Civil Rights and other independent civil rights groups have been quite critical of the adequacy of the state compliance plan reviews. *See, e.g.*, letter from chairperson of Health Task Force of the Leadership Conference on Civil Rights, *reprinted in* VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 152. Many states made certification compliance decisions for Medicaid facilities based only on paper documentation and did no on-site inspections even though required to do so under the 1966 state letter. See note 121 *supra*. In 1973, at least 16 states had no Title VI certification process at all and many had no regular monitoring activities. Overall, the OCR reviews showed compliance by states to be minimal, yet OCR has never required state agencies to report any compliance-related data on a regular basis. *1973 Hearings, supra* note 7, at 209. *See also* California health agency and other examples cited at text accompanying notes 136-140 *infra*. For a defense of the quality of these reviews, see note 134 *infra*. The 1974 report has

there were a few, sample checks of health facilities receiving federal funds to verify the declarations in the state-agency plans, but in general the review was of the agency and its plan, not of the actual facilities or institutions themselves.[134] After the initial review of a state agency and its plan, the regional OCR staff made recommendations to the stage agency. This typically resulted in negotiations followed by more recommendations, followed by more negotiations. The process often took months or years and still continues in some cases.[135]

The review of the state health agency in California[136] is illustrative. A review of the state agency's compliance plan in 1971 indicated that California had done little more than execute an assurance.[137] There was no organized system of on-site inspections or annual reviews of Medicaid facilities for Title VI compliance.[138] There was even evidence that some facilities had not been required to execute the Title VI assurance. The regional OCR's original action was simply to request voluntary compliance by the agency. In December 1972, after unsuccessful negotiations, the regional office recommended to OCR in Washington that enforcement action be initiated by means of a lawsuit or fund termination. OCR responded that formal action would be premature.[139] It was not until April 1973 that the state agency received

so many examples of pro forma compliance by state agencies that it is hard to believe that those state agencies were even acting in good faith. *See* VI ENFORCEMENT EFFORT—1974, *supra* note 4.

134. *See 1973 Hearings*, supra note 7, at 128 (testimony of Peter E. Holmes, former Director of OCR). However, Holmes also testified that since 1968, 3,300 nursing homes and hospitals were reviewed by OCR, implying that many of those were in conjunction with the state-agency reviews. *See also id.* at 316-17 (Holmes letter to the Subcommittee expanding on his remarks).

135. See text accompanying notes 136-40 *infra* and note 141 *infra*.

136. The California Department of Health Care Services administered the Medicaid program (called Medi-Cal) in California. It had an agreement with the California Department of Public Health to perform the facility certification reviews as part of that department's administration of the state's licensing program. Those California executive agencies were later reorganized into a larger Department of Health within which separate divisions administered the Medicaid (Medi-Cal) and licensing programs. The compliance-plan negotiations were conducted first with the Department of Health Care Services and later with the Department of Health. As of 1977, the California legislature was considering a further reorganization and the division of responsibility undoubtedly will be realigned.

137. *See* VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 158 n.395. *See also id.* at 158-60 nn.395-401; *1973 Hearings, supra* note 7, at 213-15.

138. VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 158 n.395.

139. *Id.* at 160. Voluntary compliance is encouraged by the spirit and letter of the Title VI regulations. 45 C.F.R. §§ 80.6, 80.8 (1977). Yet no reading of the regulations requires or permits the months of negotiations, exchanges of letters, and inaction that some of those situations entailed. *See also* Adams v. Weinberger, 391 F. Supp. 269 (D.D.C. 1975) (judicial criticism of OCR's emphasis on voluntary compliance).

formal notice of the deficiencies in its compliance plan. No formal enforcement activities were initiated, however, and the negotiations between the state agency and OCR still continue.[140] Similar situations exist and have existed in a number of states.[141]

Obviously, one of the major reasons that these reviews take so long and are subject to such criticism is the recurring problem of inadequate staffing and resources.[142] However, the shortcomings of the review procedure are complex, and much responsibility can be attributed to the manner in which the Title VI program has been carried out. OCR has never developed clear standards for state compliance plans which can be used in review activities or referred to by private parties.[143] It has issued a model statement of compliance,[144] but this statement contains little more than an agreement to abide by the law. There are no guidelines in the model statement as to what should be included in the methods of administration or in the time tables for individual program compliance. There is a draft set of guidelines for compliance plans, termed "methods of administration,"[145] but they have never been formally issued, although they are unofficially circulated and provide a starting point for individual negotiations with state agencies.[146] OCR has announced the intention to issue guidelines in final form twice, but they have never been issued.[147] OCR has also expressed the intention to implement a data-collection system to monitor state compliance rou-

140. *See* letter from Ted Scott, Civil Rights Office, Department of Health, State of California (on file with *The Hastings Law Journal*).

141. Other examples occurred in such diverse states as Louisiana, Michigan, and Indiana. VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 161-62. In Louisiana, the state health department claimed, among other things, that it did not have the staff to do Title VI certification reviews. The regional OCR allowed the agency to rely on the OCR Medicare reviews, despite the fact that Medicare reviews are done only on initial certification, and not periodically thereafter.

142. The failure to take enforcement actions can only be related to the staffing of the Office of General Counsel, HEW, where three or four people usually handle all OCR health-related legal work. Many of the "horror" stories illustrating lack of aggressive enforcement can be explained by the backlog of work in the Office of General Counsel. *See, e.g.*, ENFORCEMENT EFFORT—A REASSESSMENT, *supra* note 126, at 316, 322.

143. See notes 119-21 and accompanying text *supra*.

144. VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 146.

145. *Id.* at 147.

146. *Id.* at 147-48. Originally, there was also a handbook for compliance officers which described elements of a state compliance plan prepared for HEW by the United States Commission on Civil Rights. It is far too general in most respects but much more helpful than the federal regulations. UNITED STATES COMMISSION ON CIVIL RIGHTS, COMPLIANCE OFFICER'S MANUAL: A HANDBOOK OF COMPLIANCE PROCEDURES UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 (1966).

147. VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 144.

tinely.[148] So far this has not been done either.

Reviews of state compliance plans are lengthy and seldom effect substantial change in the states' efforts. One thing these state reviews do reveal is that the state agencies responsible for enforcing Title VI in health and welfare programs are not making a serious effort to enforce Title VI or even to monitor compliance.

Investigation of Complaints

In addition to securing assurances from direct recipients of HEW funding and conducting reviews of the compliance plans of state agencies administering federal health programs, OCR also investigates individual complaints of discrimination made against recipient health facilities. As is the case with its other activities, OCR has been less than successful in carrying out its responsibility.

Complaints against health facilities received by OCR are forwarded to the appropriate regional office. In some states the regional office refers complaints to the appropriate state agency, but this practice varies greatly from region to region and depends on the type of complaint involved and the confidence that HEW has in the particular state agency.[149]

In all cases, some kind of investigation must be conducted.[150] If the regional office determines that a complaint cannot be resolved informally or through negotiation, it recommends to OCR that enforcement action be undertaken. The director of OCR and the Office of General Counsel review all recommendations prior to further action. Usually after a long period of time, another attempt is made to secure voluntary compliance. If this attempt fails, either termination proceedings are initiated, or the matter is referred to the Department of Justice.[151]

Immediately after the enactment of Title VI, there were many complaints to OCR about health-facility violations of Title VI,[152] but

148. *Id.* at 197-98, 201.

149. *See, e.g.*, HEW AND TITLE VI, *supra* note 60, at 31; ENFORCEMENT EFFORT—A REASSESSMENT, *supra* note 132, at 308; VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 181.

150. 45 C.F.R. § 80.7(c) (1977). *But see* proposals to amend this regulation, note 167 *infra*.

151. 45 C.F.R. § 80.8(a) (1977). The same basic procedure would be used if a compliance problem were generated by a state compliance plan, a special study, a review of assurance, or compliance documentation.

152. Prior to 1968, complaints about discrimination in health facilities were reported to be coming in to HEW at a rate of two or three a week. In fact, the Health and Welfare

since 1968, there have been relatively few.[153] It is difficult to tell exactly how many complaints have been received: OCR does not compile this data, and complaints are forwarded to the central OCR only when enforcement action is recommended. Such a recommendation is not made until after an investigation and the subsequent failure of informal intervention. In 1973, the General Accounting Office (GAO) study showed that some regional offices had received only a handful of complaints in the preceeding five years.[154] In 1974, a study by the United States Commission on Civil Rights reported that OCR had received 300 complaints against health facilities nationwide, with the number varying greatly from region to region.[155] That study also found that complaint investigation occupied only about ten percent of the total time spent on health-related enforcement activities.[156]

This situation contrasts with the large number of complaints OCR receives against other programs and institutions. OCR recently announced that all Title VI complaints—primarily complaints against educational institutions—rose by 450% from 1969 to 1974,[157] and that by 1976 it had a backlog of 3,025 complaints and expected 2,455 more in 1978.[158] It is not clear why the number of complaints against health facilities has declined while the number of complaints against other programs and institutions has increased. Apparently, discrimination in health facilities still exists.[159] Perhaps the public, like OCR, is more prone to act against completely segregated facilities than to complain of the more subtle forms of discrimination that characterize health-facility activities today.

Branch (later to become HSSD) used the volume of health-related complaints to justify the few welfare enforcement activities undertaken during that period. HEW AND TITLE VI, *supra* note 60, at 30.

153. Several factors may account for the small number of complaints against health facilities. Most consumers of health services have never heard of OCR or of the Title VI enforcement program, nor could they be expected to understand the variety of governmental and quasi-governmental agencies that monitor health facilities. Many people do not even understand that most private facilities will accept a Medicaid or Medicare card; they believe these cards can be used only at public facilities. Furthermore, people seeking hospital or nursing-home care are usually more concerned with basic survival than enforcement of their civil rights.

154. *See 1973 Hearings, supra* note 7, at 209-18.

155. One hundred fifty of these complaints were against hospitals, eighty were against other health institutions, and the remainder were against welfare agencies. VI ENFORCEMENT EFFORT—1974, supra note 4, at 180.

156. *Id.*

157. 40 Fed. Reg. 24,149 (1975).

158. 42 Fed. Reg. 39,824 (1977). For an explanation of this announcement, see note 167 *infra*.

159. See notes 178-92 & accompanying text *infra*.

As with their number and frequency, the quality of complaint investigations against health facilities seems to vary greatly from region to region. The United States Commission on Civil Rights has frequently criticized the slowness and inefficiency of OCR in handling these complaints,[160] although it has occasionally praised the conduct and value of individual investigations.[161] Moreover, the few complaints received against health facilities do not seem to bring the attention of OCR to the kind of discrimination that represents the key issues in Title VI enforcement.[162] Most of the complaints appear to involve either peripheral issues[163] or the kind of individual situations that lend themselves to resolution by negotiation and OCR has thus had to bring few formal compliance actions against health facilities.[164] The evidence indicates that race discrimination and Title VI enforcement are still issues with regard to health facilities,[165] albeit more complex issues than those presented by the overt segregation that existed before 1966.[166] Complaints, like the other catalysts of enforcement, however, apparently do not raise these issues.[167]

160. HEW AND TITLE VI, *supra* note 60, at 30-31; VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 182-85. If a shortage of resources limits OCR's ability to investigate complaints, initial responsibility for investigations can always be shifted to state agencies, at least for complaints against Medicaid facilities.

161. VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 183.

162. See text accompanying notes 193-98 *infra*.

163. For example, OCR has taken actions against health facilities administered by fraternal organizations. See note 108 *supra*.

164. Between 1966 and November 1968, 54 medical institutions were cited for noncompliance; 16 were actually terminated, but 14 were eventually reinstated. From November 1968 to 1972, no new proceedings were instituted. *1973 Hearings, supra* note 7, at 206.

165. See text accompanying notes 193-98 *infra*.

166. See text accompanying notes 176-93 *infra*.

167. Even OCR has indicated a dissatisfaction with the complaint mechanism, finding it unlikely to raise important problems and time consuming for the staff. The Civil Rights Commission reported that in 1974, the OCR intended to emphasize in-depth studies rather than complaint investigation as a means of identifying critical issues. VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 187. In June 1975, OCR formally proposed changes in the federal regulations that would relieve it of the requirement of investigating all complaints and would make other changes in the administration of OCR's enforcement activities. 40 Fed. Reg. 24,148 (1975). The time for comments on this proposal was later extended. 40 Fed. Reg. 45,442 (1975). In May 1976, those proposed changes were withdrawn, and OCR issued a statement outlining the problems in handling complaints and soliciting further public comments. 41 Fed. Reg. 18,394 (1976).

Because of the change in administration and OCR leadership after the 1976 elections, there has been no further action on the regulations. The *FY 1978 Annual Operating Plan for OCR* indicated that OCR intended to reorganize complaints procedures and use 55% of its time investigating complaints (all programs). HEW, NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS, PROPOSED ANNUAL OPERATING PLAN FOR FY 1978, 42 Fed. Reg.

In-Depth Studies

In addition to the enforcement activities outlined above, OCR carries out its general responsibility to enforce Title VI in health and welfare programs through studies of particular problems and programs.[168] That activity has been particularly important to OCR since 1973, when the initial round of state-agency compliance reviews was finally completed.[169] In each annual enforcement plan since 1973, OCR has outlined a series of studies to be performed as part of the overall monitoring and enforcement efforts. For example, a sample study of nursing home referral practices was conducted in 1973[170] and a study of site selection by health facilities was proposed in the 1978 plan.[171] The description of these reviews in the 1978 plan[172] indicates that future studies will document Title VI compliance by categories of recipients. Previous OCR studies have attempted to isolate the causes of discrimination.[173]

Title VI Enforcement in Health Facilities: Ten Years Later

The reason Title VI enforcement in health facilities has drawn so little controversy and has been overshadowed by the enforcement of Title VI in the field of education could be simply that in either absolute or relative terms racial discrimination in health facilities is not an im-

39,823, 39,824-25 (1977). Apparently all complaints will still be investigated—sooner or later.

A good, well-publicized complaint system would be a valuable supplement to other more systematic data collection; it should not, however, become a substitute for data gathering or compliance monitoring. *See* Tomlinson & Mashow, *The Enforcement of Federal Standards in Grant-in-Aid Programs: Suggestions for Beneficiary Involvement*, 58 VA. L. REV. 600, 639 (1972).

168. The term "in-depth reviews" is used by the United States Commission on Civil Rights in its 1974 report. *See* VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 177. *See also 1973 Hearings, supra* note 7, at 144 (testimony of Peter Holmes). In the *FY 1978 Annual Operating Plan*, the OCR includes this sort of activity under "compliance reviews." HEW, NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS, PROPOSED ANNUAL OPERATING PLAN FOR 1978, 42 Fed. Reg. 39,823, 39,824-25 (1977). Actually OCR does a variety of studies and this categorization of their activities is fairly descriptive but not completely definitive. *See, e.g.*, studies of individual policy guidelines referred to by Holmes in *1973 Hearings, supra* note 7, at 161.

169. See text accompanying note 132 *supra*.

170. For a summary of this and other in-depth reviews in 1973 and a discussion of the results of these reviews, see VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 177-79. *See also 1973 Hearings, supra* note 7, at 148-71 (testimony of Peter Holmes) (citing factors to be considered when conducting reviews).

171. 42 Fed. Reg. 39,824-25 (1977).

172. *Id.* at 39,824.

173. VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 179.

portant problem. The policies of racial segregation or exclusion maintained by the health facilities of previous decades seem to have been eliminated either in the early years of Title VI enforcement or through the monitoring of certification since that time.[174] Virtually all hospitals and nursing homes now execute nondiscrimination agreements[175] and few cases of overt discrimination have been identified. The low priority OCR gives to enforcement activities in health facilities would be entirely justified if the low number of complaints made to the agency responsible for enforcing Title VI were an accurate measure of the frequency or magnitude of racial discrimination.[176]

At this point, however, two important and disturbing observations can be made with regard to the continued existence of substantial racial discrimination in health facilities. First, there is very little data on which to base an evaluation of the problem.[177] Second, what evidence does exist indicates little change since 1967, after the integration of health facilities that occurred incident to the initial Medicare certification efforts.[178] After 1966, the requirements of Title VI and the economic incentives of Medicaid and Medicare meant that hospitals and nursing homes could no longer maintain open policies of racial segregation or overtly exclude minorities from their services. Evidence indicates, however, that the nondiscrimination agreements are not being fully enforced and that racial discrimination in a variety of forms continues to be a problem.

In 1969, OCR sent questionnaires to all hospitals and nursing homes participating in the Medicare program. The questionnaires were similar to the compliance reports utilized in the Medicare-facility application process.[179] The results showed that on the day reported seventy-seven percent of the hospitals had at least one minority patient, representing an increase of twenty-four percent over the number served prior to Medicare. The data also indicated that thirty percent more minority patients were being served overall, and that sixty-one percent more hospitals had minority physicians on their staffs. The results also showed eighty-two percent more nursing homes were serving minorities, and the number of minority patients in nursing homes had risen

174. See notes 105-125 & accompanying text *supra*.

175. See note 75 & accompanying text *supra*.

176. See notes 153-156 & accompanying text *supra*.

177. See text accompanying notes 205, 210, 211 *infra*.

178. For a discussion of the initial Medicare certification efforts, see text accompanying notes 76-95 *supra*.

179. The results of the study are summarized in *1973 Hearings, supra* note 7, at 203-04. The full report is reprinted in *id.* at 289-315.

seventy-five percent. In 1969, minority treatment still represented less than 5.2% of the patient-days in nursing homes, however, and many of the facilities reporting no minority patients were from racially mixed areas and all had executed nondiscrimination assurances.[180] In short, services to minorities had improved and there were fewer all-white institutions, but there were still a number of institutions not serving minority patients. Further, the data suggested problems of underrepresentation and underutilization.

Underutilization of health services by minorities has been repeatedly documented in more recent years.[181] Indeed, current, national statistics show that nonwhite Americans receive less health care and yet have more health problems than do whites.[182] This relationship is apparent even when populations with equivalent abilities to pay are compared.[183] For example, in the South, white Medicare recipients receive 55% more hospital care, 95% more physician services, and 250% more care in extended care facilities than do nonwhite Medicare recipients.[184]

The only study to date analyzing Title VI compliance by health facilities was conducted by GAO in 1971, supplemented by a follow-up study in 1972.[185] GAO found that, despite the elimination of overt policies of racial discrimination, there were still vestiges of a dual system of hospitals and nursing homes; that is, most health facilities in the areas studied treated patients predominantly of one racial group.[186] For example, of the twenty-four hospitals and twenty nursing homes participating in Medicare in Atlanta and Birmingham, five institutions served sixty-seven percent of the black patients. One hospital and six nursing homes were found to have no black patients. On the other hand, a single nursing home served seventy-five percent of the black Medicare

180. *Id.* at 203.

181. For recent compilations of data on underutilization of health services by minorities, see HEW, HEALTH OF THE DISADVANTAGED CHARTBOOK (1977); CONGRESSIONAL BUDGET OFFICE, HEALTH DIFFERENTIALS BETWEEN WHITE AND NONWHITE AMERICANS (1977) [hereinafter cited as CONGRESSIONAL BUDGET OFFICE].

182. CONGRESSIONAL BUDGET OFFICE, *supra* note 181, at xi, 1, 4, 8.

183. Davis, *Equal Treatment and Unequal Benefits: The Medicare Program*, 53 MILBANK MEMORIAL FUND Q. 449, 470-71 (1975).

184. *Id.* Similarly, annual average, per-person, health-care expenditure for nonwhite Medicaid recipients was $321 in 1974 as opposed to $560 for whites. CONGRESSIONAL BUDGET OFFICE, *supra* note 181, at 18.

185. COMPTROLLER GENERAL OF THE UNITED STATES, REPORT TO THE COMMITTEE ON THE JUDICIARY, HOUSE OF REPRESENTATIVES, COMPLIANCE WITH ANTIDISCRIMINATION PROVISION OF CIVIL RIGHTS ACT BY HOSPITALS AND OTHER FACILITIES UNDER MEDICARE AND MEDICAID (1973), *reprinted in full text in 1973 Hearings*, supra note 7, at 185-263.

186. *1973 Hearings, supra* note 7, at 199.

patients in the Atlanta area.[187] Similar, although less marked, results were found in western and northern cities.[188]

GAO concluded in the 1972 study that, despite the utilization patterns, hospitals and nursing homes were generally complying with Title VI.[189] Because it found that there were no cases of overt denial of admission to minority patients or denial of staff privileges based on race and that all facilities had executed nondiscrimination agreements, GAO concluded that Title VI had not been violated. It attributed the patterns of differential minority utilization of health facilities to a number of factors, including the refusal of some physicians to take Medicaid patients, referral patterns, patient preferences, and familiarity of minority groups with certain institutions.[190] GAO also noted the special efforts of public institutions to accommodate minority needs and the fact that the outpatient departments of public hospitals were often the only source of physician care available to minority patients.[191] A difference in utilization based on these factors rather than on overt policies of discrimination was not, in GAO's interpretation, a violation of Title VI. GAO concluded that while there was some evidence of racial discrimination in some of the facilities, the evidence indicated the existence of more subtle, less overt forms of discrimination: generally negative attitudes of whites towards minorities, a lack of understanding by the staff of the cultural or economic backgrounds of minority patients, and discrimination against poor people in general. These factors and attitudes were also beyond the scope of Title VI, ac-

187. *Id.* at 202-03.

188. A study of Wayne County, Michigan (Detroit area) showed the following: "[O]f all nonwhite patients treated in nursing homes in Michigan, 84 percent were in Wayne County nursing homes. Although nonwhites represented only about 8 percent of all nursing-home patients in Michigan, they represented about 23 percent of all nursing-home patients in Wayne County . . . 21 had no nonwhite patients and an additional 32 had five or fewer nonwhite patients each. These 53 nursing homes had only 87 nonwhites among 4,670 total patients—less than two percent—whereas 57 nursing homes in Wayne County had 2,048 nonwhites among 6,152 total patients—about 33 percent . . . ." *Id.* at 235.

The use of hospitals in this same area showed that some hospitals had very few minority patients and that others, particularly public hospitals, served a very high percentage of minority patients. The different patterns of utilization, however, were not so dramatic as those of nursing homes.

In a review of Los Angeles County, GAO again reported a clustering of minorities in certain facilities, particularly public hospitals. *Id.* at 239-43. Minority patients were found to by-pass more conveniently located private facilities to seek both physician care and hospital services at county-administered hospitals. *Id.* at 249.

189. *Id.* at 198.

190. *Id.* at 220, 223-29, 249.

191. *Id.* at 254-56.

cording to the study.[192]

Do the patterns of differential utilization of health facilities by minorities that suggest a dual system of health facilities, the underutilization of health facilities by minorities, and the more subtle, less overt interpersonal problems between the staff of health facilities and their patients, constitute a racial discrimination in the sense that they actually do violate Title VI? A close examination of the factors GAO concludes are responsible for underutilization indicates that to answer this question one must do a detailed analysis of the manner in which institutionally-based medical care is delivered, the referral patterns by which patients choose or are sent to particular hospitals and nursing homes, and the extent of control over admission and treatment policies exercised by individual physicians. If, for example, an individual physician's refusal to take minority patients causes low minority utilization of the facilities to which that physician makes referrals, one must consider whether this is a violation by the hospital of the Title VI nondiscrimination agreement.[193] Similarly, if the refusal of certain facilities or physicians to take Medicaid patients causes minority underutilization, one must ask whether this overt discrimination against Medicaid patients amounts to discrimination against minorities and a violation of Title VI, given the high percentage of minority Medicaid patients in some areas.

Minority preferences for certain facilities cannot be dismissed as simply voluntary choices by individual patients. It is important to know whether minority patients are really choosing public hospitals over private facilities or if they are acting by necessity in response to the way health services are organized either within a given private institution or throughout the system.

192. *Id.* at 200-01.

193. OCR has interpreted Title VI as inapplicable to individual physicians. See note 72 *supra*. If physicians are covered by Title VI, many of the factors cited by GAO are forbidden as overt discriminatory conduct on the part of individual physicians. Aside from Title VI, the degree of control the modern hospital exercises over its nonemployed medical staff is substantial. For example, the JCAH standards that a hospital must meet for accreditation and certification include standards relating to medical staff organization, qualifications for admission to the staff, and review of patient care. JOINT COUNCIL ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS, "Medical Staff" 1-12 (1970 & 1973). The control that a hospital can exercise over nonemployed physicians is a complex legal problem that has never been addressed with regard to policies of racial discrimination. There are also economic consequences that might arise should a hospital try to exercise too much control over a staff physician's racial policies. See discussion of Cook v. Ochsner, 559 F.2d 968 (5th Cir. 1977), text accompanying notes 199-200 *infra*.

Nothing in the language of Title VI restricts it to prohibiting only overt policies of discrimination. The legislative history may well be oriented toward the prohibition of the overtly-segregated health facility,[194] but a literal reading of the statute does not confine it to such a narrow scope or preclude enforcement agencies from further examination of the more complex problems.[195] For that matter, HEW regulations[196] and, in particular, the interpretative guidelines,[197] define discrimination as including both direct and indirect action and, arguably, hold health facilities responsible for some of the factors found by GAO to cause differential utilization patterns. It is important to note that when a facility fails to provide services to minorities, it need not be shown that the facility has a racially discriminatory purpose in order to show a violation of Title VI. While discriminatory purpose or intent may be necessary to show a violation of the fourteenth amendment's requirement of equal protection, Congress may enact legislation that prohibits acts with a racially discriminatory impact even without a showing of explicit discriminatory purpose.[198] Whether or not these factors are ultimately determined to violate Title VI, differential treatment is an important problem. An analysis of the factors responsible may indicate a solution, either through Title VI enforcement or by some other means.

194. See notes 62-65 and accompanying text *supra*.

195. While many OCR officials have agreed with this narrow interpretation of Title VI, others have indicated only that those subtle or complex problems are difficult to assess and detect. The testimony of Peter Holmes, then Director of the OCR, at the 1973 hearings indicated that his office considered subtle, nonovert forms of discrimination within the scope of Title VI, contrary to the GAO testimony during the same hearings. *1973 Hearings, supra* note 7, at 132. *See also id.* at 37 (testimony of civil rights groups).

196. *See* 45 C.F.R. § 80.3 (1977).

197. See text accompanying note 164, *supra*. For text of applicable guideline, see note 217 *infra*.

198. *See* Washington v. Davis, 426 U.S. 229 (1976); McDonnell Douglas Corp. v. Green, 411 U.S. 792 (1973); Griggs v. Duke Power Co., 401 U.S. 424 (1970) (relating to employment discrimination under Title VII of the Civil Rights Act).

While the language of Title VI does not specifically address the issue, the Title VI regulations seemingly require only a discriminatory impact, 45 C.F.R. § 80.3(b)(2) (1977), and the guidelines for hospitals and nursing homes, note 217 *infra*, confirm this interpretation as applied to health facilities. The Supreme Court in a related context has upheld—at least in general terms—this interpretation of Title VI. Lau v. Nichols, 414 U.S. 563 (1974).

It therefore seems likely that Title VI will be interpreted in much the same way as Title VII, *i.e.*, that a statistical showing of disparate treatment of minorities will establish a prima facie case of discrimination such that a defendant facility will have to come forward with a showing of a legitimate, nondiscriminatory purpose underlying the practices attacked. HEW has already proceeded in this manner. N.A.A.C.P. v. Wilmington Medical Center, 426 F. Supp. 919 (D. Del. 1977); see notes 201-03 and accompanying text *infra*.

If GAO's picture of racial discrimination in health facilities and the other evidence cited are correct, then racial discrimination still represents a significant problem in health facilities, and the issues of whether responsibility for the problem can be attributed to individual facilities and, if so, whether they represent violations of Title VI should be addressed. These issues, however, can only be raised, not resolved, at this point, because the Title VI enforcement program has not brought these problems under sufficient public scrutiny to allow them to be properly examined and ultimately settled either administratively or through litigation.

In sum, the problem may continue either because a narrow view of Title VI may prevail or because the administrative process may prove unworkable when applied to the more complex forms of discrimination that currently exist. Congress may not have intended, or may not now intend, to prohibit racial imbalance in health services that occurs without overt discrimination, to allow federal agencies to try to eliminate discrimination in health services tied to housing patterns or social conditions, or to allow agencies to reorganize the manner in which health care is made available to the public. Nonetheless, nothing in the legislation precludes at least an investigation of these more complex problems. The legislation is written broadly and its implementing regulations interpret its authority expansively. Yet the enforcement program continues to react to problems that apparently no longer exist, spending little time and effort on the kind of problems that seem likely to exist. In fact, the enforcement program is unlikely to discover even overt discrimination unless it takes the form of official, institutional policy.

Recent developments, however, indicate that HEW may be changing its enforcement program. As a result, some of the complex problems of racial discrimination in modern health facilities will finally receive the kind of public scrutiny they deserve. A 1977 HEW investigation of hospitals in New Orleans, Louisiana, prompted by a consumer-initiated lawsuit,[199] revealed that several New Orleans facilities

199. In July 1970, a group of black residents of New Orleans brought suit against ten private hospitals alleging violations of the free-service and community-service requirements of the Hill-Burton program, discussed at text accompanying notes 24 and 31 *supra*, and violations of Title VI. *See* Cook v. Ochsner, 319 F. Supp. 603 (E.D. La. 1977). The Title VI allegations ranged from overt denials of admission and the maintenance of segregated rooms to the failure of the hospitals to take affirmative action to correct community attitudes resulting from past discrimination. In 1971, additional hospitals and HEW were added as defendants. The Hill-Burton allegations were severed and heard separately. *See* Cook v. Ochsner, 559 F.2d 968 (5th Cir. 1977).

are substantially underutilized by minority patients.[200] HEW has taken the position that those hospitals must take steps to increase the minority utilization or face termination of federal funding. As of July 1978, informal negotiations had broken down and HEW was proceeding towards formal administrative hearings. If a settlement cannot be reached, the courts may be faced with the first major test of the applicability of the Title VI prohibition of racial discrimination to health facilities with significant underutilization of services by minorities but no overt policy of discrimination.

Another recent lawsuit in Delaware may also force changes in the Title VI enforcement program and, possibly, in many of HEW's other programs.[201] A federal district court ruled that in making decisions

200. In response to plaintiffs' Title VI allegations, HEW admitted that it did not have sufficient information to assess the accuracy of the allegations and entered into a stipulated agreement with plaintiffs under which HEW agreed to conduct an investigation of the defendant hospitals.

In July, 1977, the Director of the Regional OCR sent letters to three of the defendants summarizing the results of the OCR investigation and formally advising the three hospitals that they were in violation of Title VI.

The OCR findings with regard to Alton Ochsner Medical Foundation are typical of all three:

"Although Ochsner may never have had a formal policy of not admitting Black patients, it has remained significantly underutilized by Blacks since its opening in 1947. It was not until 1965 that the number of Black patients for any particular year exceeded 1 percent of the total patients admitted. In 1967, out of a total of 11,651 patients admitted, 379 (3.3 percent) were Black. In 1968, out of a total of 11,839 patients admitted, 431 (3.6 percent) were Black. In 1969, out of a total of 12,027 patients admitted, 426 (3.5 percent) were Black. In 1974, the last year for which OCR has statistics, out of 14,134 total admissions, 899 (6.4 percent) were Black. . . . While the 1974 statistics indicate an increase in Black patient admittance, Ochsner remains substantially underutilized by the Black population in its service area. A study of statistics from 18 New Orleans general hospitals shows that from the area within five miles of Ochsner 14,333 Blacks were hospitalized in 1974 at the 18 hospitals. Of these, only 1.7% were hospitalized in Ochsner. Of all Whites hospitalized from this area, 10% were at Ochsner. . . . [A]ccording to the 1970 census, 31 percent of the total population of the area within five miles of the hospital is Black; 32 percent of the metropolitan New Orleans and 29.8 percent of the State of Louisiana population is Black. . . ."

Letter from Dorothy D. Stuck, Director, Office of Civil Rights, Region VI, DHEW, to Mr. L.R. Jordan, President, Alton Ochsner Medical Foundation (July 19, 1977) (on file with *The Hastings Law Journal*).

After citing those patterns of underutilization, the OCR letter made reference to the Title VI interpretive guidelines, see note 217 *infra*, and concluded that the facility must execute a plan outlining the steps that it will take to comply with Title VI.

201. In September 1976, several minority groups filed suit against several health providers and government agencies, including HEW, alleging that the reduction of services at the hospital's inner-city site, which served a predominantly black population, and the construction of a new facility in a predominantly white suburb was a violation of Title VI. *See* NAACP v. Wilmington Medical Center, 426 F.Supp. 919 (D. Del. 1977). Plaintiffs also alleged violations of § 504 of the Vocational Rehabilitation Act of 1973, 29 U.S.C. § 794

under the federal "certificate of need"[202] program, HEW, as well as state and local planning agencies, must consider the Title VI implications of all proposed projects for capital expenditures.[203] If the principle behind this ruling is upheld, nearly all hospitals and nursing homes will be required to assess the impact on minorities of all substantial capital expenditures[204] in order to meet federal standards and to ensure

(Supp. V 1975) and the National Environmental Policy Act of 1969, 42 U.S.C. § 4321 (Supp. V 1975).

Specifically, plaintiffs contended that the planning agencies and HEW had approved the hospital's application under the federal "certificate of need" program, described in note 202 *infra* without consideration of the impact on the minority population in the inner city in violation of Title VI regulations related to site location: "[I]n determining the site or location of a facilities (sic), an applicant or recipient may not make selections with the effect of excluding individuals from, denying them the benefits of, or subjecting them to discrimination under any programs to which this regulation applies, on the ground of race, color, or national origin; or with the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the Act or this regulation." 45 C.F.R. § 80.3(b)(3) (1977). See also text accompanying note 216 *infra*. The site-location requirement appears for the first time in the 1973 revision of the Title VI regulations, and was later added to the regulations of 21 agencies. *See* 38 Fed. Reg. 17,978, 17,979 (1973).

202. Section 1122 of the Social Security Act, 42 U.S.C. § 1320a-1 (1974), allows a state to enter into an agreement with HEW under which the state will determine whether new capital expenditures by health faciliites are "necessary." If found to be unnecessary, HEW is authorized to withhold a portion of the reimbursement to the facility under the Medicaid and Medicare programs proportionate to the cost of the unnecessary expenditure. Thus, the federal law authorizes a limited, certificate-of-need program. Plaintiffs alleged that comliance with Title VI should be one of the considerations in determining whether or not a facility had met the criteria for "need" under § 1122.

203. NAACP v. Wilmington Medical Center, 426 F. Supp. 919 (D. Del. 1977). After lengthy study and substantial negotiations between all the parties, HEW concluded: "We have concluded that Plan Omega contains many features which will assist in assuring that WMC retains its ability to deliver high quality health care to all segments of the New Castle County population, equally and in settings which are not racially isolated. However, other aspects of Plan Omega threaten this goal and must be altered by way of plans and assurances (to be discussed, *infra*) to avoid a finding of noncompliance with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehbilitation Act of 1973. Absent such measures, OCR believes that the new facility is likely to serve only a very small segment of the county's minority population and would become almost exclusively the responsibility of the older, urban, and increasingly racially identifiable and segregated facility." Letter from Dewey E. Dodds, Director, Region III, HEW, to James A. Harding, President, Wilmington Medical Center, Inc., July 5, 1977, at 4 (on file with *The Hastings Law Journal*).

As a result, HEW concluded that the relocation of the hospital's services would be a violation of Title VI unless the hospital provided adequate transportation for the currently served (minority and handicapped) patients to the new site, established an ombudsman for patient complaints, initiated other outreach and patient education activities, and took other steps to prevent discrimination and to avoid the spectre of separation. *Id.* at 22-27.

The defendant hospital submitted a compliance plan to HEW which was formally accepted on November 1, 1977. Plaintiffs, however, have proceeded with their suit claiming that the plan is inadequate.

204. In order to fall within the requirements of § 1122, a capital expenditure must ex-

continued federal funding. Although the outcome of these controversies is far from settled, they may represent the beginning of a new phase of Title VI enforcement in health facilities and a more realistic approach to the problem of racial discrimination.

Recommendations for Administrative Change

The Title VI enforcement program in health facilities should address the more complex problems of racial discrimination rather than simply ensure that health facilities do not have overt policies of racial discrimination. To achieve that goal, OCR monitoring and enforcement efforts will have to include a more realistic assessment of the kind and amount of services provided to minorities by facilities subject to Title VI.

A major shortcoming of the Title VI enforcement program in the past has been that it produced no data from which Title VI compliance could be evaluated. The data generated by GAO study cited earlier provides[205] an adequate basis for a preliminary assessment of racial discrimination in health facilities and the potential causative factors thereof. Unfortunately, OCR has never attempted to compile data of this kind on a regular basis. To perform its functions, OCR must regularly collect and analyze data indicating the kind and amount of services provided to racial minorities. The data presumably gathered by state agencies in their reviews of Medicaid nursing homes[206] are neither collected, nor analyzed, by OCR; the data remains in the hands of the state agencies. Furthermore, the agency data consists of only a one-day census of a facility's patients and a questionnaire survey of its policies.[207] A realistic enforcement program would require a more sophisticated inquiry into the quality and quantity of services regularly delivered to discover the kinds of racial discrimination likely to exist today. For example, if referral practices are likely to be responsible for differential patterns of utilization, data reflecting patient admissions by race, source of referral, and type of admission (e.g., emergency, elective, incident to outpatient visit, etc.) should be collected. Complete data might be collected only on a sample basis, or only after some statistical information or individual complaint indicated a need for further inquiry into a facility. Data adequate to monitor Title VI

ceed $100,000, change the bed capacity, or substantially change the services available at a facility. 42 U.S.C. § 1320a-1(g) (Supp. V 1975).

205. See notes 185-92 & accompanying text *supra*.

206. See text accompanying notes 126-48 *supra*.

207. See description of monitoring forms at note 75 *supra*.

compliance, however, should be collected from all health facilities on a routine basis. Discrimination in health services delivery, in contrast to discrimination in other areas, is difficult to detect without routine evaluation of the services delivered. Health services of all kinds result from a series of individual decisions made under the most private of circumstances: there is little opportunity for third-party scrutiny unless procedures are designed and implemented specifically to elicit the factors influencing those decisions.[208]

Despite limitations on agency resources and priorities, good data collection is feasible. Health facilities are inspected, reviewed, and scrutinized by a variety of government and nongovernment agencies for a variety of purposes, many of which perform functions similar to the monitoring of services to minorities.[209] OCR could collect the necessary data on discrimination in health facilities by simply increasing the scope of those examinations. Data collection by such a means would increase only minimally the cost and work expended by either the monitoring agency or the monitored facility. For example, a sample could be taken of a facility's services to minorities and then broken down by reimbursable services as part of the cost reimbursement determinations under Medicaid or Medicare procedures.[210] Data collection techniques, procedures, and forms would have to be altered somewhat, but once implemented, data collection would be relatively easy.[211] If the administrative resources are not available to allow HEW to act on their findings, at least the data should be made available to the public and to the Congress.

The simple truth is that at this point we know virtually nothing about the delivery of health services in terms of racial discrimination, despite the decade of experience of an agency responsible for monitoring compliance with Title VI. It speaks for itself that in Title VI litigation HEW has had to admit to its inability to determine recipient compliance.[212]

Related to the need for improved data collection is the need for additional and more realistic definitions of standards and procedures by which Title VI can be monitored and enforced in health facilities.

208. In some cases, the act of discrimination is prior to the admission of the patient. *See* NAACP v. Wilmington Medical Center, 426 F.Supp. 919 (D. Del. 1977).

209. See text accompanying notes 107-13 *supra*.

210. See text accompanying 74 & 112 *supra*.

211. The data collected would have to depend on the substantive standards of OCR and decisions as to the kinds of differential treatment attributable to the health facility. See discussion of substantive guidelines at text accompanying notes 213-17 *infra*.

212. See note 200 *supra*.

The Title VI regulations that specify prohibited practices[213] are generally too vague to allow an assessment of anything beyond the validity of the admissions policies of recipient facilities. The interpretive guidelines[214] for hospitals and nursing homes are sufficiently specific in terms of the issues that they do address, but there is a question as to their validity and enforceability.[215] In any case, additional interpretive guidelines will be necessary to respond to the new problems that will be identified if effective monitoring efforts are introduced.[216]

Other substantive issues which are defined only vaguely in the regulations or guidelines will also require further specification.[217] It is

213. See note 62 & accompanying text *supra*.

214. See note 68 *supra*.

215. Unlike other OCR standards nominally entitled "guidelines," *e.g.*, guidelines for elementary and secondary school desegregation, which are published in the *Federal Register*, the guidelines for hospitals and nursing homes were not issued through normal rule-making procedures. The guidelines are written in letter form under the signature of a former director of the OCR and circulated by OCR staff; public notice in the broad sense is quite limited. If they are to be taken seriously and withstand legal attack on their validity, they should be published and clearly made part of agency policy.

216. 426 F.Supp. 919 (D. Del. 1977). See notes 201-04 & accompanying text *supra*. *NAACP v. The Wilmington Medical Center* is a good example of the type of situation which will require further policy clarification by the OCR. Without further clarification of the application of the site-location regulation to expansion or capital improvement of a health facility, it will be difficult for a facility to decide whether or not a proposed project complies with Title VI absent an individual determination by OCR. Similarly, it will be impossible for OCR to monitor compliance with this provision unless it undertakes a case by case investigation of the hundreds of site-selection or relocation decisions made every year. More specific definition of the policy behind this regulation and the procedures that a facility must follow to have a proposal approved will be necessary in light of the OCR's overextended position and its limited ability to conduct investigations.

217. *E.g.*, the first page of both the guidelines for hospitals and for nursing homes cited in note 68 *supra* state: "Where there is a significant variation between the racial or ethnic composition of the resident census and available population census data for the service area or potential service area, the (nursing home or hospital) has a responsibility to determine the reason for such variation and take whatever action may be necessary to correct any discrimination." The guideline is a sufficient statement of basic policy, but it is surely insufficient as a statement of the kinds of factors that a facility must necessarily correct unless the guideline is interpreted literally to require "whatever action may be necessary." There must be more specific definition of the actual intent of that requirement. The causative factor for variation in racial composition may be a lack of bilingual services, a failure to encourage minority patients to use a facility, or the personal policies of a facility's staff physicians. As certain specific factors become identified as major issues, further specification of this policy will be necessary if it is actually to be enforced.

As another example, on several occasions the OCR has taken the position, unsupported by applicable guidelines, that Medicare providers must have bilingual capabilities when a significant number of the beneficiaries of their programs are non-English speaking racial minorities. VI ENFORCEMENT EFFORT—1974, *supra* note 4, at 137. In addition, Lau v. Nichols, 414 U.S. 563 (1974), held that a school district must provide a bilingual educational program where a significant number of students are non-English speaking. The application

important for the OCR to generate such guidelines, because the staff and resources of OCR limit its investigative capabilities to a maximum of one or two major health-related cases at any one time. Effective guidelines will decrease the need for extended facility-by-facility determinations. This is not meant to suggest that OCR should be locked into substantive standards of such specificity that there is no room for the exercise of discretion. Standards, whether in the form of regulations or interpretive guidelines, should allow OCR sufficient discretion to apply Title VI to the wide variety of circumstances that can arise in the health-facility context.[218] The present standards, and particularly the Title VI regulations, however, do not adequately delineate basic policy. Application of these standards to the complex issues often encountered in modern health facilities is extremely difficult and perhaps meaningless.

As important as clarification of the substantive standards for applying Title VI is, it is equally important to adequately delineate the procedural responsibilities of OCR, its regional offices, state health agencies, and individual health facilities. Even a close reading of the regulations, guidelines, and other related material does not give a clear picture of who is doing what to whom. Monitoring and enforcement activities specifically intended for health facilities should be spelled out, even if the Title VI enforcement program in health facilities continues to have the same focus that it currently has. This change must include a detailed delineation of the enforcement responsibilities of OCR and the state agencies.

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of that principle to private health facilities is an open question. Unlike publicly sponsored education or social-welfare programs, health facilities can argue they are providing an essentially private service. Yet the provision of health care is not wholly private in character where it is funded totally or partially with government funds. This is another of those complex situations where there is clearly a discriminatory impact and the difficulty lies in identifying the responsibility for the causative factors. It is difficult to ignore the likelihood that a health facility in, for example, a Spanish speaking area that does not have Spanish speaking capabilities must know the impact on service to minorities. Arguably this would be prohibited under 45 C.F.R. § 80.3(b)(2) (1977) and under the hospital or nursing home guidelines *supra*. OCR apparently agrees; a draft policy on bilingual services is under consideration, but like so many other critical decisions, it has not been completed and is "still being studied."

For another possible issue with great potential impact on health facilities, see 45 C.F.R. § 80.3(b)(1)(vii) (1977) (denial of participation in planning or advisory bodies on the basis of race).

218. The usual discretion necessarily vested in administrative agencies may be outweighed by the countervailing need for specific standards and procedural requirements in order to insure that an agency with conflicting purposes carries out its regulatory as well as spending functions. *See* Note, *Enforcing a Congressional Mandate: LEAA and Civil Rights*, 85 YALE L.J. 721, 733-36 (1976); text accompanying note 225 *infra*.

A reevaluation of agency procedures would probably reveal inconsistencies[219] and noncompliance due to either the increasingly bureaucratic nature of the procedures involved or to more willful inaction. If procedural responsibilities were clarified, the public would be better able to scrutinize the effectiveness of the program, and OCR's enforcement efforts could focus on the critical, substantive issues of racial discrimination in health facilities.[220]

Another matter that should be reevaluated is the considerable portion of OCR's resources and attention devoted to state-agency compliance plans and attempts to ensure that such plans are adequate for enforcing Title VI.[221] The emphasis on state enforcement activities is conceptually appealing, but has not been effective; in fact, such emphasis has diverted OCR from more productive activities. Although the state agency compliance plans could be a critical part of the Title VI enforcement program in health facilities, the plans are neither clearly defined by the agency responsible for monitoring their effectiveness nor known nor available to either the public they are designed to protect or the facilities they are designed to control. Guidelines, or preferably regulations, clarifying state-agency responsibilities and the standards for adequate compliance plans should be issued. Certainly there has been sufficient experience with this aspect of Title VI enforcement for OCR to do so.[222]

An enforcement program for health facilities that relies on the establishment of specific standards and on the collection of data undoubtedly leaves fewer available agency resources for agency-initiated, in-depth studies[223] or the investigation of complaints,[224] at least in the short run. Even if the standards are developed and the data collection procedures are defined and implemented, such a program would primarily define and identify racial discrimination in health facilities. It would do little to resolve such problems or effectively enforce the nondiscrimination policy that underlies Title VI. These objectives can be

219. For example, the state Medicaid agency must monitor nursing homes but not hospitals. See notes 113, 121 *supra*.

220. *See* Tomlinson & Mashow, *The Enforcement of Federal Standards in Grant-in-Aid Programs: Suggestion for Beneficiary Involvement*, 58 VA. L. REV. 600, 617 (1972). The authors argue that procedural rather than substantive requirements are more likely to be enforced since compliance (and noncompliance) is easier to determine with regard to the former.

221. See text accompanying notes 126-48 *supra*.

222. See text accompanying note 132 *infra*.

223. See text accompanying notes 168-73 *supra*.

224. See text accompanying notes 149-67 *supra*.

met only if the resources available to OCR drastically increase from present levels. Given the history of Title VI enforcement in health facilities, however, this is unlikely, and such enforcement will probably continue to be low priority for HEW. Consequently, OCR may not be expected to do much more than identify problems. Further, more serious sanctions such as fund termination are not likely to be used frequently even if OCR resources are increased, because most HEW programs are not designed to regulate but to promote social-welfare activities through the expenditure of funds. Such programs foster formal and informal, cooperative arrangements with the institutions that receive federal funds and generally try to encourage the participation and the cooperation of private facilities in health programs. In such a context, mandatory enforcement of civil rights, especially in the form of termination of funding, may be opposed by considerable internal and external pressure. It should be expected that fund termination, even when threatened, is infrequently carried out and that the HEW bureaucracy or leadership rejects cutbacks in its funding programs as a tool to carry out public policy.[225]

On the other hand, if the reality of racial discrimination in health facilities were better known, we would be able to confront the issue of OCR's unwillingness and inability to solve the problems that do exist. Individuals suffering the consequences of racial discrimination would be in a better position to take remedial action. Congress could devise new strategies for coping with the problems, bolster efforts currently being made, or admit satisfaction with the status quo. At present we avoid the problem of racial discrimination in health facilities by allowing it to remain poorly defined.

Conclusion

With respect to the modern American health facility, Title VI is an illusory promise and an unused tool of public policy. The signing of a Title VI assurance form by a hospital or a nursing home is little more than the execution of another boilerplate form, one of many incident to the receipt of federal funds. Enforcement activities concerning health

225. Despite the reluctance of funding agencies to use termination as a regulatory tool, the termination of funds to health facilities can be an appropriate sanction under some circumstances without causing drastic harm to program beneficiaries. In situations involving education or welfare programs, the termination of a program usually hurts the ultimate beneficiary of the program more than the recipient institution. In the Medicaid-Medicare situation, however, the sanction will affect the institution, not the beneficiary, because multiple facilities provide medical services to the public.

facilities have been paper-shuffling exercises; with a few exceptions, they have not been directed towards implementing a policy of nondiscrimination or towards solving the real problems of racial discrimination in health facilities. Consequently, important policy and legal issues wait first to be defined and then to be settled. At stake are the lives and well-being of thousands or millions of people.

The Title VI enforcement program could be greatly improved if it focused on collecting adequate data as a means of monitoring services by health facilities to minorities and on developing substantive standards defining Title VI violations in the health-facility context. Without better monitoring and clearer standards for determining compliance, the real problem of racial discrimination in health facilities will never be defined or addressed, let alone resolved.

Once identified, even the most complex problems of racial discrimination in health facilities can conceivably be solved. State and federal governments are currently attempting to reform the delivery of health care through a broad range of programs affecting everything from the cost of health care to its method of delivery and the quality of its outcome. If either an expanded interpretation of the Title VI policy of nondiscrimination were formulated or if the prohibition of discriminatory treatment became an explicit policy objective of the state and federal programs, racial discrimination in health facilities, in whatever form it exists, could be confronted and, one hopes, eliminated.

That we are at a point when major reform in the delivery of health services is likely is critical to the evaluation of Title VI enforcement. Conversely, the history of the Title VI enforcement program in health facilities may be important to an understanding of the nature of the problem we now confront in the delivery of health services. If the general goal of reform in the delivery system is to make an essentially private industry more responsive to the needs of the public, then it is important to note that the attempts of government agencies to monitor and enforce compliance by private health facilities with the public policy against racial discrimination have not been remarkably successful.