Civil Rights In A Changing Health Care System

Managed care has the potential to expand access to care for the poor, but it can also lead to new discrimination against minorities.

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PROLOGUE: At the height of the health care reform debate following President Clinton’s election in 1992, the Congressional Black Caucus Health Braintrust Forum predicted that the preeminence of managed competition could cause health care reform to become “the civil rights battle of the 1990s.” Nearly four years later that prediction has not come true—at least not overtly. However, civil rights advocates continue to express concern that the disenfranchised—the poor and ethnic minorities—could be left behind as the U.S. health care system undergoes a major transformation to managed care. Sara Rosenbaum and colleagues write in this paper, “The reemergence of discrimination . . . might be particularly likely if health system changes foster the types of fear and resistance that historically have triggered discriminatory conduct (and laws).”

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ABSTRACT: Title VI of the 1964 Civil Rights Act prohibits discriminatory conduct by recipients of federal financial assistance. The law has been used in the past to challenge discrimination in health care. The evolution of the health care system from fee-for-service to managed care holds much promise for minority persons, who historically have faced serious, extensively documented barriers to health care access. However, managed care providers, like their fee-for-service counterparts, may perpetuate past discriminatory practices in new ways. Understanding new forms of discrimination is important at this stage of the development of managed care, when program design and policy action can most effectively prevent the occurrence of such practices.

Even after the end of de jure segregation in the United States, private hospitals, some of which received federal financial assistance, continued to discriminate on the basis of race, color, and national origin. These discriminatory practices included the denial of admission to persons who lacked a personal physician with staff privileges, the refusal either to participate in Medicaid or to extend staff privileges to physicians who accepted Medicaid patients, and the transfer of Medicaid patients to public institutions. Such practices disproportionately affected persons of color and effectively barred minority patients from care.

As with all social legislation, segregation laws were grounded in private attitudes, beliefs, and conduct that survived well beyond their repeal and that persist into the present. Years after the enactment of laws barring discrimination, federally assisted institutions (including even venerable charitable hospitals) maintained discriminatory admissions and treatment policies. These practices had their greatest impact on the very persons for whom closed health care doors should have opened following the enactment of Medicare and Medicaid.

Today many of these practices are relics of the past. Hospital participation in federal payment programs is near universal; indeed, many institutions maintain programs that are designed to accommodate the needs of minority populations, such as language and cultural assistance and hospital-affiliated clinics for persons without private physicians. States have universally adopted their own antidiscrimination legislation.

What happens when one system of health care is replaced by another? Do old practices reemerge in new forms? If so, what might these new forms of discrimination look like? Is there any evidence that discrimination in health care might be occurring today? These are important questions as the U.S. health care system undergoes perhaps its greatest organizational and legal transformation since the proliferation of health insurance in the mid-twentieth century. The reemergence of discrimination in new forms might be par-
particularly likely if health system changes foster the types of fear and resistance that historically have triggered discriminatory conduct (and laws). Ironically, despite its emphasis on deregulation and its reliance on market theory, managed care has the potential to regulate relationships between providers and patients and between individuals and insurers in unprecedented ways. Indeed, it is managed care’s very potential to force a private health care system to provide access and services to all members of the system that may trigger a flare-up of discrimination in new forms. Prejudice may ebb over time, but it never disappears.

Discrimination in managed care is an important issue not only because of hypotheses concerning its potential effect. A veritable mountain of research continues to document evidence of widespread disparities between minority and nonminority persons in health status and access to both primary and specialty health care. In the face of this evidence, it is neither possible nor legally or morally defensible to cease searching for the causes of these disparities and working to eliminate them.

As with discrimination in a fee-for-service context, it will take many years, extensive study, and a greater understanding of the intricacies of managed care practice to interpret the impact of the new system. However, we believe that early evidence from managed care suggests both the existence of discriminatory practices and areas of potential concern in which greater research is warranted.

We begin this paper with an overview of Title VI of the 1964 Civil Rights Act. We then examine past health care institutional practices that have been identified as discriminatory under the fee-for-service system and consider their counterparts in the world of managed care. For reasons of space limitation, we have limited our study to issues related to discrimination on the basis of race and national origin. Of equal importance is discrimination on the basis of disability, sex, and age, all of which are also prohibited under federal statutes.

The Civil Rights Act: An Overview

Title VI of the 1964 Civil Rights Act, which is part of a landmark set of civil rights legislation, was enacted to prohibit the expenditure of federal funds on activities and programs that discriminate on the basis of race, color, or national origin. Over the past three decades Title VI and its companion civil rights statues—Title VII, prohibiting discrimination in employment on the basis of sex, and Title VIII, prohibiting discrimination in housing—have changed the American landscape as few other pieces of modern social legislation have.

Title VI prohibits discrimination in any “program or activity” that
receives “federal financial assistance.” “Program or activity” encompasses all operations of entities, agencies, businesses, or corporations receiving federal assistance, not merely the component of the entity that receives federal funds. Furthermore, the prohibition against discriminatory conduct applies to all persons served by the recipient, regardless of which sponsor actually pays for a particular service. “Federal financial assistance” includes direct aid such as grants, loans, and advances of federal funds as well as indirect aid such as Medicare and Medicaid payments. The act requires federal agencies to monitor recipients of federal financial assistance to ensure their compliance with the law and to respond to administrative complaints filed by individuals. Title VI also requires that states, as grantees of federal funding, similarly monitor and enforce compliance with the statute.

Regulations originally promulgated in 1965 by the U.S. Department of Health, Education, and Welfare remain in force today. These rules define what types of activities and practices by federally assisted grantees constitute discrimination and set forth procedures for remedying discriminatory conduct. The regulations bar both intentional acts of discrimination and activities that are neutral on the surface but that have a discriminatory effect. They also prohibit recipients of federal funds from subjecting persons to segregation or separate treatment on the basis of race or from establishing facility locations with discriminatory effects.

No matter how significant, not every disparity in health care amounts to a possible violation of Title VI. The law effectively makes discrimination on the basis of race or national origin a federal tort. As with other torts, a successful Title VI–based claim involves proving that a defendant’s conduct or practices (as opposed to other intervening factors) are the proximate cause of the harm, which in this case is discrimination against minority persons. Thus, for discrimination to be found to exist under Title VI, a plaintiff must show that a defendant recipient of federal financial assistance (within the meaning of the law) has engaged in actions that either are intentionally discriminatory or have a statistically significant discriminatory effect on one or more minority groups. In a case alleging discriminatory effect, a plaintiff must identify one or more “facially neutral” practices (practices that do not have any discriminatory intent) that have a statistically significant disparate impact on a protected minority group. The burden then shifts to the defendant to demonstrate that the challenged practice has a “manifest relationship” (is vitally necessary) to the defendant’s program. If the defendant persuades the court that the challenged practice is a necessary part of its program, the plaintiff still may prevail by showing
that the defendant may achieve its stated objectives through means that have a less discriminatory effect.

The existence of a statistically significant disparity is measured in relation to the area in which the defendant provides its services, offers its benefits, or conducts its business. For example, if a plaintiff were to allege discriminatory admission practices by a hospital whose service area covers a county, then disparate impact against minorities presumably would be measured by comparing the facility’s inpatient census against the proportion of racial or ethnic minority persons residing or using health care services in the county. Additionally, the presence of minority patients would have to be adjusted for their risk status. For example, given the higher incidence of low birthweight among African American babies, where half of the county’s births are African American, one would expect that more than half of all infants in the hospital’s neonatal unit would be African American. Were minority infants to account for only 25 percent of the facility’s neonatal intensive care patients, then a statistically significant disparity might be present.

**Discriminatory Policies And Practices: From Fee-For-Service To Managed Care**

The practices identified as discriminatory in *Cook v. Oschner Foundation Hospital et al.* (the case that marked the end of discrimination on the part of private hospitals) were systemic in nature; that is, they flowed from the structure and operation of the health care system of that time. Understanding the systemic consequences of certain industry conduct is essential to civil rights law and practice. Indeed, as with any law that addresses the conduct of private industries, effective civil rights advocacy must be able to identify industry activities that might in fact be the cause of statistically disparate treatment. This in turn depends on having a high level of understanding of how the enterprise in question operates. Because the health care industry is so vast and complex, the number of civil rights challenges to its conduct have been few in relation to civil rights efforts in other human service areas with similar histories of *de jure* segregation, such as education.

- **Providers’ discretion to select patients.** The *Cook* case illustrates the importance of understanding how a market industry operates and how its practices can alter access among selected populations. *Cook* involved health care sellers (hospitals and physicians) that perpetuated discrimination by maintaining control over the selection of their customers (patients). Historically, physicians and hospitals in the United States have had complete discretion to select their patients. Even after passage of laws that curbed this discre-
tion, the industry sought to perpetuate it by using several different methods that could be spotted only by those who understood the industry. These practices included not recognizing as legal certain forms of tender commonly used by minority patients (that is, refusing to care for Medicaid enrollees); refusing to provide services to purchasers who were not already members of the sellers’ organization (for example, persons without a private physician who had staff privileges at the hospital in question); and not permitting market entry (for example, staff privileges) by sellers who were in fact willing to accept the legal tender offered by minority patients (that is, physicians who participated in Medicaid).

In managed care the issue of acceptance of the legal tender that disproportionately is held by minority patients is moot. Managed care companies that do not sell services to Medicaid or Medicare or another federally funded sponsor probably would not be considered recipients of federal financial assistance for purposes of Title VI enforcement (although their conduct might be subject to scrutiny under state human rights laws or other laws). The focus of civil rights interest necessarily is on those companies that do participate in Medicaid and Medicare. However, mere participation in federally assisted programs does not end the discussion, but becomes the starting point for consideration of discriminatory practices.

The nature of managed care. In considering how civil rights law applies to managed care, it is important to first consider the managed care system itself. For purposes of this paper we define managed care as any insuring system in which the insuring organization either requires or encourages persons to obtain insured services through a network of participating providers. Providers are selected by the managed care organization and are subject to its controls as a condition of employment or as part of their contractual agreement. Under this definition, managed care includes both traditional health maintenance organizations (HMOs) and preferred provider organizations (PPOs) as well as other “new-age” managed care entities such as physician/hospital organizations (PHOs) and integrated service networks (ISNs).

In contracting with public and private sponsors, managed care organizations can offer what appears to be the same product to different purchasers while still maintaining critical distinctions. For example, a managed care entity may offer a specific product (such as an HMO) that differs from sponsor to sponsor with respect to covered benefits, cost sharing, and degree of control over provider access. A “fancier” (and more expensive) HMO product might include a point-of-service option permitting enrollees to use nonnetwork providers without sacrificing coverage. For a higher premium, cov-
verage also might be more generous, with broader benefits and lower cost sharing. Rules on prior authorization and self-referrals also might vary depending on the premium: The looser the controls over enrollees and network providers, the higher the premium and the steeper the cost sharing. The fact that poorer enrollees (who may be disproportionately minority) do not have coverage for the fancier product line may be unfortunate but not discriminatory. This is no different from the “old” world in which well-heeled patients getting bypass surgery enjoyed private rooms and personal nursing, while Medicaid patients were treated on wards.

One might also expect a managed care plan’s product to vary from sponsor to sponsor with respect to certain aspects of the provider network. Managed care plans contract to deliver care, not merely to cover it. The delivery network must be accessible. Thus, one would not expect a plan to assign low-income patients to inaccessible physicians. One also might expect a plan to expand its network in certain communities to ensure inclusion of bilingual or “culturally competent” providers. In short, a single health plan product might in fact contain significant coverage and structural variations depending on the purchaser.

The two sides of managed care. Even with more limited benefits and tighter controls over access and use, managed care has the potential to improve access to care for the poor. Given the historic access barriers that have confronted Medicaid beneficiaries, it is easy to understand why state Medicaid agencies and many beneficiary groups alike have been attracted to managed care. However, the very characteristic that gives managed care its power—the promise of care—also gives the system a powerful reason to discriminate against patients who are considered costly, difficult, and above all, undesirable. At their extreme, managed care plans’ controls can result in the segregation of certain racially identifiable enrollee groups into health care systems that are less accessible and of poorer quality than are plans offered to other organization members. Unlike the differences noted above, these differentials in treatment may have no legitimate business basis.

Managed care is the joining together of two actors—insurers and health care providers—with a history of discrimination. Insurers’ efforts to avoid loss may lead to practices that may have little or no basis in actual evidence of financial exposure and that may simply reflect attitudes and beliefs about certain groups that pose a financial risk. In the case of health care providers, the nature of the managed care agreement with the plan raises more specific issues. Providers that are members of plan networks typically are required to accept all patients referred by the plan as a condition of participa-
tion. The most vivid recent example of managed care’s phenomenal impact on providers’ historic autonomy to select their patients was the firestorm created by TennCare’s (Tennessee’s Medicaid program) “cram-down” rule, which compelled physicians who sought participation in the Tennessee Blue Cross PPO network to treat TennCare patients as a condition of network membership. In short, one of the most unprecedented and least appreciated aspects of managed care is its impact on physicians’ autonomy not only to treat patients but to select them as well. Ironically, in the case of managed care, the underservice that conceivably could result from disparate access and treatment policies might be viewed as a cost-cutting achievement rather than a problem.

Managed Care’s Potential To Discriminate

In fee-for-service medicine, discrimination has occurred both at the point of entry into the health care system and in the care of persons within the system. Documented discriminatory point-of-entry practices have included refusal to participate in Medicaid, imposing qualifications unrelated to skills (such as membership in a local medical society) as a means of barring minority physicians and physicians who treat minority patients from membership on hospital staffs or making practice by such professionals more difficult, maintaining segregated waiting rooms and hospital wards, barring services to persons without personal physicians with staff privileges, imposing arbitrary caps on the number of publicly insured patients, failing to make information about programs and services language-accessible, and intimidating certain types of patients to discourage them from seeking services. Location or relocation of services also has been challenged as discriminatory, as have other practices that were designed to make facilities less accessible, such as ambulance patterns that divert publicly insured patients away from certain facilities and policies that require all appointments to be made by telephone (which reduces access among patients without telephones). While less common, there are examples of discrimination against persons who are receiving care within a system: segregated patient wards, service reductions that fall with unequal weight on minority groups, and specialty practice guidelines that, while ostensibly neutral, disproportionately curtail care to minority patients.

It is possible to visualize managed care versions of each of these past practices, and anecdotal reports indicate that there is in fact evidence that these practices are occurring. As with fee-for-service medicine, discriminatory conduct within managed care systems might occur both at the point of entry and to patients receiving care. In a prepayment system the desire to enroll as many “covered lives”
as possible may help to mitigate against point-of-entry discrimination, although certain types of discriminatory practices may still exist. The more significant forms of discrimination (and possibly the harder to discern) may be against enrollees in the system who are permitted to receive differential treatment under the terms of the contract between agencies and plans.

- **Service area and enrollment.** Managed care organizations might seek contracts that are limited to certain service areas. For example, plans might seek to avoid service areas located in inner-city areas with high concentrations of minority beneficiaries in favor of more suburban areas with lower proportions of minority residents.\(^9\) Even if plans maintain “open doors” in suburban service areas, the use of service networks that skirt certain communities is tantamount to the selective location of facilities and services uncovered in past discrimination cases.

Similarly, plans can discriminate in enrollment by failing to contract with providers that traditionally have been used by beneficiaries. Such plans are in effect selecting service locations that may be less accessible to minority patients. To be sure, if the providers are not qualified or if their numbers exceed plan needs, an exclusionary practice may be defensible; however, in light of the fact that Medicaid beneficiaries tend to be located in medically underserved areas, the defense of excess numbers does not appear to be plausible in many cases. To the extent that provider qualification requirements have a disproportionate adverse impact on minority providers or the care-seeking patterns of minority patients, the plan may be in violation of the regulations noted above that prohibit use of methods of administration that have a discriminatory effect. Similarly, plans’ failure to advertise in certain parts of a service area can result in biased enrollment as well. In short, a plan that avoids bidding on certain communities or that avoids contracting with providers serving predominantly minority community residents can either overtly or covertly avoid serving minorities. These patterns all have direct precedent in discrimination in the traditional health care system.

- **Selection and formation of provider networks.** It is in the area of provider network selection and formation that perhaps the most significant problems are beginning to emerge. This issue is directly analogous to the historical problems of staff privileges for minority physicians and physicians serving minority patients illustrated by the *Cook* case. This type of discrimination involves not only minority enrollees but also minority physicians, who may find themselves subject to differential plan treatment and member assignment patterns. Possible forms of discrimination against minority physicians include outright bars to network membership through selec-
tion practices that use requirements such as board certification (a status held less commonly by minority providers), even though less restrictive credentialing pathways to ensure provider quality might be available. \(^{19}\) Minority providers also may find that they are invited to join plan networks only for certain sponsored groups of patients and not for other groups. For example, minority providers might be in the public group panel of providers but might not qualify for referral of privately sponsored enrollees.

**Use of segregated provider networks.** There also is evidence that managed care plans are maintaining segregated provider networks for both primary care and specialized services that cannot be explained by the residential location of the providers, the special skills or services of certain providers, or the special needs of patients. A recent study by the New York City Office of the Public Advocate uncovered widespread evidence of segregated networks of providers within health plans serving areas in which both Medicaid and privately sponsored enrollees reside. \(^{21}\) In other words, within a single service area, plans appear to be giving Medicaid enrollees access to only a portion of their provider networks, even though the Medicaid patients are demonstrably underserved. According to officials, when asked about this practice, managed care plans claimed that they maintained segregated networks to appease their member physicians. New York State’s 1995 request for bids does not prohibit this practice; indeed, a number of state contracts and bid requests reviewed by the George Washington University Center for Health Policy Research permit the use of Medicaid-only provider networks. A state Medicaid program might insist (correctly, in our opinion) that managed care networks include providers with specific skills or attributes. However, having contractual specifications for an enhanced network to serve Medicaid beneficiaries is quite different from countenancing the use of more restrictive networks because of providers’ preferences.

**Practices that diminish quality or accessibility.** There are numerous ways in which Medicaid managed care arrangements appear to differ from those that organizations use for commercial sponsors. For example, anecdotal evidence suggests that it is common for Medicaid managed care enrollees not to be given access to participating provider lists until after they have selected a managed care plan (even then, evidence suggests that members still cannot obtain lists of providers). Knowing who providers are before selecting a plan is basic to consumer satisfaction, access, and quality and is a fundamental tenet of commercial managed care. \(^{22}\) Yet state Medicaid agency contracts with plans do not commonly insist on beneficiaries’ right to inspect provider lists prior to selection. In-
Indeed, many contracts do not require plans to permit enrollees to select their providers at all, even after enrollment. Instead, contracts and bid requests indicate that provider selection should be permitted “where practicable.” A managed care plan could use such latitude to gerrymander the assignment of members to certain providers; resulting assignment patterns could diminish both access and quality.

Plans also might use different coverage and benefit determination procedures for Medicaid and non-Medicaid members. Given the difference in premiums, it is likely that plans (and even the same plan offered to different purchasers) will vary greatly in the mix of services they cover. However, it would be inappropriate for a plan to vary by group sponsor the length of time required for prior authorization or the frequency with which a drug formulary is updated and mailed to participating providers. Grievance and member service arrangements also might differ, as might provider/patient ratios and practice guidelines. In other words, while coverage and certain network rules might differ for different groups of purchasers, the methods by which a plan is administered should be similar for all sponsored groups.

**Discussion And Recommendations**

The evolution of the nation’s health care system from fee-for-service to managed care holds much promise for persons who historically have faced major health care barriers. The service duties created by managed care contracting are particularly important to Medicaid beneficiaries, particularly those who are from historically underserved ethnic minority groups. Thus, the integration of service delivery and health care financing potentially represents a major step forward in basic health care access.

However, managed care also has the potential to continue past discriminatory practices in new forms. Because managed care combines insurance with health care delivery and imposes strict controls on access (especially in the case of Medicaid beneficiaries), it could reinforce past discriminatory tendencies and also lead to new forms of discrimination. Because the financial structure of managed care rewards service reduction and cost avoidance, provider conduct that would have been viewed with concern a generation ago might be touted as an accomplishment in a managed care era, particularly in the case of high-cost populations.

Managed care is still in relative infancy; it therefore is important to recognize these possible problem areas and take preventive steps to reduce the potential for discrimination. Some observers might view the issue simply as differential care based on payer status and
consider such differentials justifiable, given the higher health risks posed by the poor and the lower premiums frequently paid by Medicaid agencies. However, many of the issues we have raised do not appear to be linked to the cost of care so much as they are to historic provider treatment preferences and the desire of insurers to avoid risk. Moreover, it does not matter under Title VI that there is no intent to treat publicly insured persons differentially; where the effect of the differential treatment falls disproportionately on minority patients, a possible Title VI violation is present.

In the managed care era it is important to ensure that the new health care system does not perpetuate and deepen practices found in the old system. But saying this and doing it are two different matters. Applying thirty-year-old antidiscrimination statutes to a new health care system will require concerted work by the Health Care Financing Administration (HCFA), which oversees Medicare and Medicaid, the Department of Health and Human Services (HHS) Office for Civil Rights, state civil rights offices, the managed care industry itself, and persons with experience in managed care and civil rights law.

First, there is a need for the collection of plan structure, process of care, and treatment information that provides federal and state agencies with data across payers. It is not sufficient to have data about plan treatment of beneficiaries alone. While Medicaid-specific information is needed to ensure compliance with Medicaid-specific contract provisions, it is not sufficient in determining the existence of access and treatment disparities among enrollee groups. Federal law requires federal agencies to maintain an enforcement scheme. Whether enforcement is in the form of response to individual complaints or general compliance monitoring, across-the-board data are required. Across-the-board data collection has been used for years in the case of enforcement procedures for hospitals. In this regard, treatment of health plans should be no different. Although the courts appear unwilling to order federal agencies to collect these data, the federal government has the discretion to do so and, we believe, a duty to develop some type of enforcement scheme. 24

Beyond questions of data collection and analysis are more basic policy decisions. In a health care system that has changed this much, illustrative examples of possible discriminatory practices are essential. State purchasers and industry officials should not be left with-
out guidance regarding the types of practices that the federal government deems unlawful. High on the list for immediate attention are issues related to selective marketing and selection of service areas, the use of provider credentialing practices that discriminate against minority providers and patients, differential methods of administration, and the use of segregated provider networks. These are issues that do not appear to require years of data collection. Indeed, they appear to be new-age versions of deeply rooted practices in the fee-for-service system.

Finally, we believe that there is a significant need for further research into the ways in which facially neutral policies and practices of providers and plans can depress health care access and use by minority enrollees. The literature on racial and ethnic disparities in health care has devoted insufficient attention to exploring the ways in which the conduct of the health care system itself can cause differences in minority patients’ use of both primary and specialized health care services. Additional study is needed to determine the ways in which modification of current practices can promote greater use of appropriate care by minority patients and further their access to care.

The research for this paper was supported in part by The Henry J. Kaiser Family Foundation.

NOTES
1. See, for example, Cook v Ochsner Foundation Hospital et al., 61 F.R.D. 354 (E.D. La. 1972). The federal court in New Orleans ruled that the plaintiffs had raised valid claims under both Title VI of the 1964 Civil Rights Act and the Hospital Survey and Construction Act (also known as the Hill-Burton Act). As with Title VI, the Hill-Burton Act’s community service requirements prohibit the denial of care for any reason unrelated to a person’s need for care.

2. Consider, for example, the practices of Denny’s restaurant chain that were brought to light in the early 1990s. These practices entailed a systemic effort to avoid giving service to black customers through a variety of means, including written rules against hiring and promotion, pervasive nonservice, and the institution of an “advance payment” rule for African American customers only (a practice eerily reminiscent of the preadmission deposit requirements used by certain hospitals to deter minority patients from admission and outlawed in the case of Hill-Burton facilities in 1979). See H. Kohn, “Service with a Sneer,” The New York Times Magazine (6 November 1994): 43.


Regarding discrimination in health care, see, for example, D. Falcone and R.


5. 42 U.S. Code, sec. 2000d-4a, as amended by Section 6 of P.L. 100-259, the Civil Rights Restoration Act of 1988. This provision was added to overturn the Supreme Court’s decision in *Grove City College v Bell*, 465 U.S. 555 (1984), in which the court limited the reach of the law to only those programs or activities within an institution that directly received the federal funds.

6. See 45 C.F.R. 80 App. A (1993); *United States v Baylor University Medical Center*, 736 F.2d 1039 (5th Cir. 1984). Although the statute at issue in *Baylor* was Section 504 of the Rehabilitation Act, the court’s finding that Medicare and Medicaid reimbursement constitutes federal financial assistance is based on its analysis of Title VI.

7. See 42 U.S. Code, sec. 2000d-1 and its implementing regulations. Persons may also bring direct legal action in court to challenge a violation of the act or implementing regulations without first exhausting administrative remedies.

8. 45 C.F.R. 80.

9. *Connecticut v Teal*, 457 U.S. 440, 446 (1982); and *NAACP v Medical Ctr.*, 657 F.2d 1322, 1332 (3rd Cir. 1981) (“To establish a prima facie case under Title VI . . . some definite, measurable disparate impact is required.”). Some courts have used the “80 percent” trigger as the threshold for discrimination, which requires a finding that the challenged practice results in a selection rate for the protected class that is less than 80 percent that for the group with the highest selection rate. *Fudge v City of Providence Fire Dept.*, 766 F.2d 650, 658-9 n. 10 (1st Cir. 1985); and *Firefighters Inst. for Racial Equality v City of St. Louis*, 616 F.2d 350, 356 (8th Cir. 1980). Other courts have held that a statistically significant disparity occurs if the selection rate for the protected class is greater than two or three standard deviations from the expected rate for that class. *Castaneda v Partida*, 430 U.S. 482, 496 n. 17 (1977); and *Hazelwood School District v United States*, 433 U.S. 299, 309 n. 14 (1977). Courts have based the requirements for proving a Title VI violation on those required to prove a violation of Title VII of the 1964 Civil Rights Act. See *Georgia State Conference of Branches of NAACP v Georgia*, 665 F.2d 1403, 1407 (11th Cir. 1985). However, “[a]t least one commentator has argued persuasively that because Title VI obligations attach only where a public or private entity has voluntarily accepted federal funds, those obligations should be more strictly enforced, and defendants’ justifications given significantly less deference than in the Title VII context where coverage is unavoidable and unrelated to the receipt of federal funding.” A. Jenkins, “Title VI of the Civil Rights Act of 1964: Racial Discrimination in Federally Funded Programs,” in *Civil Rights Litigation and Attorney Fees Annual Handbook*, ed. B. Wolvowitz et al., citing Watson, “Reinvigorating Title VI.”

11. R. Rosenblatt, S. Law, and S. Rosenbaum, *Law and the American Health Care System* (New York: Foundation Press, forthcoming). The only exception to the patient selection autonomy given health care providers can be found in the case of hospitals built with Hill-Burton funding, which must make their services available to the community; hospitals covered by Title VI and other federal civil rights laws, which are prohibited from engaging in exclusionary admissions practices; and hospitals that participate in Medicare and thus are subject to the Emergency Treatment and Active Labor Act.


14. For example, many Medicaid contracts with managed care plans permit plans to seek disenrollment for “noncompliant” patients, commonly defined as patients who fail to keep appointments, do not follow instructions, or threaten providers. It is not unheard of for states to allow plans to avoid certain patients altogether. New York State’s 1995 Request for Proposals provides that “[h]ealth plans may not refuse an assignment or seek to disenroll a member or otherwise discriminate against a member on the basis of age, sex, race, physical or mental handicap/developmental disability, national origin, or type of illness or condition, except when that condition can better be treated by another provider type . . .” (emphasis added). There does not appear to be any study suggesting that the poor are any more noncompliant than similarly situated private enrollees. Indeed, in 1994 testimony before the House Energy and Commerce Committee at a Chicago field hearing on managed care for the poor, officials from one managed care company selling services to both publicly and privately insured persons indicated that while the poor were sicker than their other patients, they were easy to manage because they “never asked for services.”

15. Rosenbaum et al., *Negotiating the New Health Care System*.


17. For example, physicians in public practice have reported that private physicians in their communities refuse to permit them to participate in “call groups,” a practice that makes their practice more difficult. Also, see *Glana v Vernick*, 756 F.Supp. 632 (D. Mass. 1991); *In re Madera Community Hospital* (O.C.R. Region IX, 1981); *Linton v Carney*, 779 F.Supp 925, 1990 U.S. Dist.; *In re Community Memorial Hospital of San Buenaventura* (HHS Office for Civil Rights Docket no. 09917801) (failure to provide notices in English and Spanish about interpreter services in patient admissions packets violates Title VI); and a complaint filed with the HHS Office for Civil Rights alleging that a U.S./Mexico border hospital dressed its security personnel in uniforms virtually identical to those worn by federal Border Patrol to frighten away undocumented persons. *In re McAllen Medical Center* (HHS Office for Civil Rights, filed January 1991), cited in Perkins, “Race Discrimination in America’s Health Care System,” in *Clearinghouse Review*, 871.

18. Regarding location of services, see *Bryan v Koch*, 627 F.2d 612 (2d Cir. 1980), in which the court stated that while it was questionable whether New York City’s decision to close a Harlem hospital created a sufficiently adverse disparate impact on minority Harlem residents to violate Title VI, the city’s justification for its decision was adequate; *Jackson v Conway*, 476 F.Supp. 896 (E.D. Mo. 1979), aff’d 620 F.2d 680 (8th Cir. 1980), in which the court used an
effective foreclosure standard to rule that there was no clear showing of discriminatory impact stemming from the city of St. Louis’s decision to relocate acute inpatient facilities and certain emergency department and outpatient facilities to a hospital more than three miles away, because the increased distance that residents would have to travel did not constitute an effective denial of care; and United States v Bexar County, 484 F.Supp. 855 (W.D. Tex. 1980), in which the court held that the plaintiffs were unable to prove that the relocation of inpatient maternity and newborn nursery services from downtown San Antonio to another hospital located eleven miles away would have a disparate impact on minority residents, because a shuttle service provided transportation between the two sites and because the higher quality of care available at the new site more than offset transportation problems. In contrast, a federal judge in California issued a preliminary injunction enjoining hospital construction in Latimore v County of Contra Costa, No. C 94-1257 SBA (N.D. Calif. 1984). The court found that the county’s decision to rebuild its sole hospital on its original site had a disproportionate adverse impact on the county’s minorities; most of whom lived in areas that were not adequately served by public transportation routes that reached the hospital. The court dissolved its injunction four months later after the county quadrupled the number of shuttles linking minority communities to the hospital.


20. In a study of managed care organizations, board certification was ranked only sixth as a measure of physician quality. S.E. Palsbo et al., HMO Industry Profile, 1993 ed. (Washington: Group Health Association of America, 1993), 49–52.

21. “Two Lists: Commercial and Medicaid Managed Care Providers” (New York: Office of the Public Advocate of New York City, 1995). After obtaining provider lists (with great difficulty) for six managed care plans that offer products to both Medicaid and commercial sponsors, the public advocate determined that plans maintained two provider lists, one for Medicaid patients and one for other patients. Even network providers within ZIP codes in which Medicaid enrollees resided were not on the Medicaid list. This suggests that these providers were not placed off limits to guard against the selection of a geographically inaccessible provider, but for some other reason. This report followed shortly a separate report from the New York State Department of Health detailing lengthy waiting periods for basic health services for Medicaid managed care patients.

22. The National Association of Insurance Commissioners (NAIC) has noted this as a potential access discrimination problem and drafted the Model Managed Care Provider Network Adequacy Act (Washington: NAIC, 1995). Specifically, the model regulation prohibits carriers from maintaining networks that discriminate against providers that serve populations “presenting a risk of higher than average claims, losses or health service utilization.”

23. For example, a standard service contract between managed care plans and a state Medicaid program recently reviewed by the center allowed plans up to 120 days from the date of a patient’s initial request for an appointment to schedule a new patient visit. The same plan conceivably could use a more prompt time frame for measuring the appropriateness of new patient visits in the case of private enrollees.