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Bridging Health Equity and Civil Rights: How Federal Funding Agencies Can Reduce Disparities and Discrimination in Healthcare Using Civil Rights Mechanisms

NEELAM SALMAN,[†] GOLDA PHILIP[††] & SARAH WILLIAMS[†††]

[†] Neelam Salman is the Section Chief for Civil Rights Coordination and Compliance within HRSA's Office of Civil Rights, Diversity, and Inclusion, where she serves as an agency expert in federal civil rights laws as they relate to diversity, equity, inclusion, and accessibility. Neelam began her federal career as a Presidential Management Fellow at the HHS Office for Civil Rights and continued post-fellowship advancing civil rights regulatory and enforcement initiatives. Neelam received her Juris Doctor from American University Washington College of Law and her Bachelor of Arts from the University of Maryland, College Park. Neelam is honored to have written and published this article alongside her mentors.

[††] Golda Philip is the Senior Advisor for Equity for the HRSA Maternal and Child Health Bureau where she works to reduce disparities and achieve health equity in maternal and child health. Golda has served in leadership positions across several federal agencies with a focus on advancing equity, diversity, and inclusion for the federal workforce and for individuals accessing services funded by the federal government. Golda received a Bachelor of Arts with honors from Stanford University, a Masters of Public Health from Tufts University School of Medicine, and a Juris Doctor from Northeastern University School of Law.

[†††] Sarah Williams serves as acting Deputy Office Head of the National Science Foundation's Office of Equity and Civil Rights. For over a decade, Sarah has worked to promote Civil Rights, Equal Employment Opportunity, and Diversity, Equity, Inclusion, and Accessibility in federally funded programs and federally conducted activities. Sarah earned her Bachelor of Arts from Missouri State University and a Juris Doctor from Saint Louis University School of Law with a Certificate in Health Law. Despite Sarah's passion for equity and civil rights, she believes that the full credit for this article lies with Neelam Salman and Golda Philip. Their ferocious minds and generous hearts conceived and nurtured this article to completion; Sarah merely babysat on occasion.

INTRODUCTION

> Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death. I see no alternative to direct action [in order to] raise the conscience of the nation.[1]

The civil rights movement was a social, legal, and political struggle by communities that are underserved to achieve equality across all facets of life. For decades, civil rights leaders advocated for legal protections based on individual characteristics, such as race, which formed the foundation of discriminatory structures and practices in the United States. The push to end inequality and segregation resulted in the passing of the Civil Rights Act of 1964, a landmark legislation outlawing discrimination on the basis of race, color, religion, sex, and national origin.[2] Thereafter, Congress enacted supplementary civil rights laws that extend protections to individuals discriminated against due to disability, age, race, familial status, and other bases.[3]

Congress charged Executive departments to use federal civil rights laws as a tool to address discrimination across healthcare, housing, education, and other social determinants of health ("SDOH") that improve well-being and quality-of-life.[4] SDOH, or the conditions in a social environment in which people are born, live, work, and play, affect a wide range of health and

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[1] Charlene Galarneau, *Getting King's Words Right*, 29 J. HEALTH CARE FOR POOR & UNDERSERVED 5, 5 (2018).

[2] Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241 (codified as amended in scattered sections of 42 U.S.C., ch. 21) (quoting Dr. Martin Luther King, Jr., Press Conference for the Medical Committee for Human Rights, 1966).

[3] *See* Civil Rights Act of 1964, Pub. L. No. 88-352, § 601, 78 Stat. 252, 252 (codified as amended at 42 U.S.C. § 2000d); Rehabilitation Act of 1973, Pub. L. No. 93-112, § 504, 87 Stat. 355, 394 (codified as amended at 29 U.S.C. § 794); Education Amendments of 1972, Pub. L. No. 92-318, Title IX, 86 Stat. 373 (codified as amended at 20 U.S.C. §§ 1681–1688); Age Discrimination Act of 1975, Pub. L. No. 94-135, 89 Stat. 713 (codified as amended at 42 U.S.C. §§ 6101–6107); Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (codified as amended in scattered sections of 42 U.S.C., ch. 126); Fair Housing Act, Pub. L. No. 90-284, 82 Stat. 73 (1968) (codified as amended in scattered sections of 42 U.S.C., ch. 45).

[4] *See* Title VI of the Civil Rights Act of 1964 at 45 C.F.R. pts. 80, 81; Section 504 of Rehabilitation Act of 1973 at 45 C.F.R. pts. 84, 85; Title IX of the Education Amendments of 1972 at 45 C.F.R. pt. 86; Age Discrimination Act of 1975 at 45 C.F.R. pts. 90, 91; Title II of the Americans with Disabilities Act of 1990 at 28 C.F.R. pt. 35; FHA complaint processing procedures at 24 C.F.R. pt. 103; Exec. Order No. 13,166, 65 Fed. Reg. 50,121 (Aug. 16, 2000) (requiring federal agencies to take reasonable steps to provide meaningful access to services by individuals who have limited English proficiency); Exec. Order No. 11,063, 27 Fed. Reg. 11,527 (Nov. 20, 1962) (prohibiting discrimination in the sale, leasing, rental, or other disposition of properties and facilities owned or operated by the federal government or federally funded); Exec. Order No. 12,892, 59 Fed. Reg. 2,939 (Jan. 17, 1994) (requiring federal agencies to affirmatively further fair housing in their programs and activities); Exec. Order No. 12,898, 59 Fed. Reg. 7,629 (Feb. 11, 1994) (requiring federal agencies to conduct programs, policies, and activities that substantially affect human health or the environment in a manner that does not exclude or other subject people to discrimination based on race, color, or national origin); and Exec. Order No. 13,217, 3 C.F.R. 774 (2001) (requiring federal agencies to evaluate their policies and programs to determine if any can be revised or modified to improve the availability of community-based living arrangements for people with disabilities).

quality-of-life outcomes.[5] Studies have shown that certain populations who have systematically experienced discrimination, based on race, sex,[6] gender, age, disability, or other characteristics, also suffer disparities in health.[7] Federal efforts to eliminate health disparities have taken an expansive approach given the complex relationship that exists between health disparities, access to care, socioeconomic status, and the environment.[8] Because discrimination adversely affects health at the structural level (e.g., limiting opportunities, resources, and well-being of certain groups) and the individual level (e.g., being subjected to insensitive comments, violence, or other kinds of harm), federal civil rights laws play a significant role in the healthcare context.[9]

Federal civil rights laws promote access for communities that are underserved[10] to population-level SDOH, such as safe and affordable housing, higher education, and quality health care services, through two methods: enforcement and proactive education.[11] Civil rights enforcement offices respond to specific instances of discrimination and the laws they enforce provide potential remedies for victims of discrimination when there is a violation. Members of the public have several options to initiate the enforcement process. Depending on the law, they may sue the discriminatory entity in federal court, file a complaint with a federal civil rights enforcement agency, or both.[12] Federal agencies may also begin the enforcement process by initiating a compliance review[13] to determine

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[5] U.S. DEP'T OF HEALTH & HUM. SERVS., THE SECRETARY'S ADVISORY COMMITTEE ON NATIONAL HEALTH PROMOTION AND DISEASE PREVENTION OBJECTIVES FOR 2020: PHASE I REPORT: RECOMMENDATIONS FOR THE FRAMEWORK AND FORMAT OF HEALTHY PEOPLE 2020 21 (2008).

[6] It is important to note that sex and gender are not analogous terms and have distinct implications in the context of SDOH, public health, and health care. The Centers for Disease Control and Prevention define sex as an individual's biological status (e.g., male, female, intersex, etc.), which is assigned at birth and associated with physical attributes, such as anatomy and chromosomes. Gender is defined as the cultural roles, behaviors, activities, and attributes expected of people based on their sex. This paper includes sex to remain consistent with its use in civil rights laws (e.g., Title IX of the Education Amendments' prohibition on the basis of "sex").

[7] U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 5.

[8] *Disparities*, HEALTHY PEOPLE 2020, https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities (last visited Mar. 31, 2022).

[9] *Discrimination*, HEALTHY PEOPLE 2020, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/discrimination (last visited Mar. 31, 2022).

[10] The term "underserved communities" refers to "populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life." Exec. Order No. 13,985, 86 Fed. Reg. 57,848 (Oct. 19, 2021). Examples of such communities include Black, Latino, Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. *Id.*

[11] *Social Determinants of Health*, HEALTHY PEOPLE 2020, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health (last visited Mar. 31, 2022).

[12] *Civil Rights Offices of Federal Agencies*, U.S. DEP'T OF JUST., https://www.justice.gov/crt/fcs/Agency-OCR-Offices (last visited Mar. 31, 2022).

[13] U.S. COMM'N ON C.R., ARE RIGHTS A REALITY? EVALUATING FEDERAL CIVIL RIGHTS ENFORCEMENT: 2019 STATUTORY ENFORCEMENT REPORT 15 (2019). Some federal civil rights regulations require enforcement offices to conduct proactive compliance monitoring to address

whether a federally funded entity is meeting its requirements under one or more civil rights laws.

Typically, the federal agency that provides financial assistance to a recipient is responsible for enforcing civil rights laws as appropriate.[14] Outside of civil rights enforcement offices, funding agencies have several mechanisms available to strategically complement and enhance enforcement efforts to help recipients comply with federal civil rights laws. This article will cover what funding agencies currently do and how they can use proactive approaches—such as providing technical assistance, conducting data collection and research, and utilizing grant process mechanisms—to assist funding recipients with compliance and avoid civil rights violations.

This article will use the Department of Health and Human Services ("HHS")[15] and one of its funding agencies, the Health Resources and Services Administration ("HRSA"), as a case study to demonstrate how HRSA uses civil rights laws, proactive efforts, and funding mechanisms to promote health equity and reduce health disparities. In addition to highlighting HRSA's work, this article will explore approaches that funding agencies across the federal government can utilize to promote compliance and reduce health disparities.

On a departmental level, HHS incorporates advancing community health and well-being into its mission, focusing on providing effective health and human services, and fostering developments in medicine, public health, and social services.[16] "Achieving health equity, . . . eliminating health disparities, and ensuring optimal health for all Americans are overarching goals of [HHS sub-agencies.]"[17]

HRSA is the primary funding agency for HHS focused on improving access to healthcare by people who are geographically isolated and economically or medically vulnerable. In addition to funding affordable and quality healthcare programs, HRSA educates recipients on civil rights laws as a means of reducing health disparities, achieving health equity, and

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comprehensive systemic issues. Enforcement offices may periodically initiate compliance reviews to evaluate the policies, procedures, and practices of funding recipients to ensure they are fulfilling their civil rights obligations. *See id.*

[14] Recipients, such as universities, sometimes receive grants from multiple federal departments and, as a result, are under overlapping federal jurisdictions. Although there are no formal federal guidelines that delineate multiple departmental jurisdictions, civil rights enforcement offices coordinate to determine which office will investigate certain elements of each case. In 2019, Michigan State University, a recipient of funding from HHS and the Department of Education, entered into separate resolution agreements with the two departmental entities based on violations under Title IX of the Education Amendments. *More Than 30 Tasks Completed in First Year of Federal Review*, MICH. STATE UNIV. (Sept. 1, 2020), https://msutoday.msu.edu/news/2020/tasks-completed-first-year-federal-review.

[15] Disclaimer: The views expressed in this publication are solely the opinions of the authors and do not necessarily reflect the official policies of HHS or HRSA, nor does mention of the department or agency names imply endorsement by the U.S. Government.

[16] *About HHS*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/about/index.html (last visited Mar. 31, 2022).

[17] OFF. OF HEALTH EQUITY, HEALTH RES. & SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH EQUITY REPORT 6 (2017).

ensuring compliance with federal law.[18] Specifically, HRSA's Office of Civil Rights, Diversity, and Inclusion ("OCRDI") provides funding recipients with resources, consultations, and technical assistance to help prevent discrimination before it results in harm to a person seeking health care and a costly enforcement action. Beyond avoiding harm, preventative interventions can result in more efficient spending by funding recipients on accessibility services and reduces the risk of liability-based actions related to discriminatory treatment.

Fifty years after Congress passed the Civil Rights Act, the federal government's efforts to fulfill its promise—to increase access by populations that are underserved to the conditions and services that improve the lives of every American—continue. Funding agencies have the unique opportunity to utilize methods outside of civil rights enforcement, such as providing technical assistance, conducting research/data collection, and utilizing grants mechanisms, to assist specific groups of funding recipients in ensuring compliance with the law. The implications of discrimination and mistreatment of certain populations are profound and require a multi-level approach on health that addresses the needs of all members of the population. The federal government's efforts are crucial in achieving these goals.[19]

I. DEFINING EQUITY AND HEALTH DISPARITIES

For purposes of this article, the table below defines key terms and definitions that will be used frequently throughout this paper.

TABLE 1.

Key Terms	Definitions
Equity	The consistent and systematic fair, just, and impartial treatment of all individuals.[20]
Health Disparity	A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.[21] Health disparities often adversely affect groups of people who have systematically experienced greater obstacles to health based on race, ethnicity, gender, age, disability, or other characteristics historically linked to discrimination or exclusion.[22]

[18] U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 16.

[19] The information provided in this article is not intended to be, nor should it be construed as, legal advice. The views expressed do not necessarily represent the views of the HHS or the United States. Instead, all content and links in this article are for general informational purposes only.

[20] Exec. Order No. 14,035, 86 Fed. Reg. 34593 (2021).

[21] U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 5.

[22] *Id.*

Social Determinants of Health	Conditions in the social environment in which people are born, live, learn, work, and play that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These social and demographic characteristics have been shown to have powerful influences on health and well-being at the individual level (e.g., gender, race, ethnicity, socioeconomic status, education, language, disability status, etc.) and population level (e.g., higher education, affordable housing, access to health care, transportation infrastructure, etc.).[23]
Health Equity	The absence of disparities or avoidable differences among socioeconomic and demographic groups or geographic areas in health status and health outcomes, such as disease, disability, or mortality.[24]

Health disparities are rooted in a complicated system of social, cultural, economic, political, medical, and legal issues that result in poorer health outcomes for populations that are underserved. Analyzing disparities in health and improvements in SDOH are critical components in achieving health equity.[25] Healthcare providers, researchers, and policymakers recognize that conditions outside of a physician's office have an adverse impact on patients' health.[26] While a person may spend an hour in a healthcare provider's office, they reside in communities with different levels of access to education, housing, quality healthcare, transportation, and other population-level SDOH.

Addressing health disparities requires a comprehensive look at society as well as the impact of federal policies and programs on the health of the population. Many individuals in the United States face inequity in sectors that influence health, such as housing, employment, access to care, transportation, and other population-level SDOH. Civil rights laws provide protections based on race, national origin, disability status, age, sex, and primary language by prohibiting discrimination based on these characteristics, many of which are SDOH linked to health disparities.

While civil rights laws have combatted many instances of overt racist policies,[27] institutionalized racism—the systematic laws, policies, and procedures that lead to differential access to goods, services, and opportunities—can still be found in everyday structures, conditions, and facets of life.[28] Some health disparities can be traced to policies that

[23] OFF. OF HEALTH EQUITY, *supra* note 17, at 9.
[24] *Id.* at 6.
[25] *Id.* at 4.
[26] CODE, LEVERAGING DATA ON THE SOCIAL DETERMINANTS OF HEALTH (2019).
[27] *See infra* Part II.
[28] Camarilla Phyllis Jones, *Levels of Racism: A Theoretic Framework and a Gardener's Tale*, 90 AM. J. PUB. HEALTH 1212, 1212 (2000).

(intentionally or unintentionally) exclude communities based on race, immigration status, or other characteristics. The connection between social inequalities and health can be described as a "stream" of causation.[29] Living conditions, institutional power, and social inequalities are factors "upstream" to the individual—meaning mostly out of his or her control—that influence health behavior (e.g., smoking, physical activity), likelihood of disease and injury, and life expectancy. The collection of these upstream factors may be characterized as SDOH.

Health disparities affecting racial/ethnic minorities such as Black, Asian, Indigenous, and Latino individuals are well-documented. Studies have shown that these groups have a higher prevalence of chronic conditions along with higher rates of mortality and poorer health outcomes, when compared with Whites.[30] For example, there is a higher incidence of aggressive forms of cancer (such as breast cancer, prostate cancer, and cervical cancer) in Black communities than in other racial groups due to higher rate of late diagnoses and infrequent use of screening tests.[31]

Health disparities are not limited to race.[32] A 2011 study by Johns Hopkins University of White and Black residents in a low-income, integrated neighborhood concluded that one of the chief contributors to healthcare disparities was not race, but access to quality health care services.[33] Other studies have reached the same conclusion.[34] Some healthcare experts have linked lack of access to healthcare to unemployment, finding that most Americans rely on employer-provided insurance; therefore, unemployed adults have poorer mental and physical health and are less likely to receive needed medical care and prescription drugs due to cost.[35] Additionally, workplace policies and factors—such as working hazardous jobs, access to safety equipment, and exposure to toxins—all have significant impacts on health.[36]

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[29] BAY AREA REGIONAL HEALTH INEQUITIES INITIATIVE, APPLYING SOCIAL DETERMINANTS OF HEALTH INDICATOR DATA FOR ADVANCING HEALTH EQUITY 4 (2015).

[30] Ananya Mandal, *What are Health Disparities?*, NEWS MEDICAL (Feb. 26, 2019), https://www.news-medical.net/health/What-are-Health-Disparities.aspx.

[31] *Why Research on Cancer Health Disparities Is Critical to Progress Against the Disease*, NAT'L CANCER INST. (Sept. 1, 2021), https://www.cancer.gov/research/areas/disparities.

[32] *Tackling Cancer Heath Disparities: Small Steps, Big Hopes*, NAT'L CANCER INST. (July 24, 2017), https://www.cancer.gov/research/areas/disparities/health-disparity-studies.

[33] Thomas LaVeist et al., *Place Not Race: Disparities Dissipate in Southwest Baltimore When Blacks and Whites Live Under Similar Conditions*, 30 HEALTH AFFS. 1880, 1884 (2011).

[34] Edward Kennedy, *The Role of the Federal Government in Eliminating Health Disparities*, 24 HEALTH AFFS. 452, 452 (2005); *see also* a 2013 study found that women who had longer travel times to reach radiation therapy facilities and rely on public transportation have difficulty in completing recommended radiation therapy due to inadequate access to radiation facilities. Lucy A. Pepins et al., *Racial Disparities in Travel Time to Radiotherapy Facilities in the Atlanta Metropolitan Area*, 89 SOC. SCI. & MED. 32 (2013).

[35] ANNE K. DRISCOLL & AMY B. BERNSTEIN, U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH AND ACCESS TO CARE AMONG EMPLOYED AND UNEMPLOYED ADULTS: UNITED STATES, 2009-2010 (2012).

[36] THE CTR. FOR POPULAR DEMOCRACY, FATAL INEQUALITY: WORKPLACE SAFETY ELUDES CONSTRUCTION WORKERS OF COLOR IN NEW YORK STATE (2013).

Americans spend ninety percent of their time indoors—with two-thirds of that in their own homes—meaning housing is a very strong predictor of health outcomes.[37] Decent, affordable, and safe housing is, therefore, another significant population-level SDOH. Studies have linked a high risk of homelessness with a greater likelihood of experiencing poor mental health, preventable hospitalizations, and negative health outcomes for all family members, including children.[38]

Researchers also identify education as a vital SDOH. Higher education can lead to improved physical and mental health through informing decisions regarding a person's health and shaping employment opportunities.[39] Conversely, people with low levels of education are more likely to experience a number of health risks, such as obesity and substance use compared with individuals with high levels of education. [40] Education as well as employment are noteworthy SDOH because they are two of the most modifiable indicators of health, and strongly correlate with life expectancy and other health status measures.[41]

It is important to note that SDOH often intersect and shape experiences in healthcare and overall health in disadvantageous ways. Intersectionality refers to how different identities simultaneously affect an individual's experiences through overlapping systems of oppression.[42] Angela P. Harris and Aysha Pamukcu identify three distinct but interrelated pathways—population, place, and exercise of power—that produce health disparities through intersectionality within each pathway and across multiple pathways.[43] A well-documented example of intersectionality within a pathway—population—arises for racial and ethnic minorities who are also part of the LGBTQ+ community.[44] Racial/ethnic minorities across the U.S. are less likely to have health insurance and access to quality healthcare.[45]

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[37] Lindsey Wahowiak, *Healthy, Safe Housing Linked to Healthier, Longer Lives: Housing a Social Determinant of Health*, 46 THE NATION'S HEALTH 1 (2016).

[38] MARJORY GIVENS ET AL., UNIV. WIS. POPULATION HEALTH INST., 2019 COUNTY HEALTH RANKINGS: KEY FINDINGS REPORT (2019).

[39] Janki Shankar et al., *Education as a Social Determinant of Health: Issues Facing Indigenous and Visible Minority Students in Postsecondary Education in Western Canada*, 10 INT. J. ENV'T RSCH. PUB. HEALTH 3908, 3908–09 (2013).

[40] *Health Disparities*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 24, 2020) https://www.cdc.gov/healthyyouth/disparities/.

[41] Wahowiak, *supra* note 37, at 1.

[42] Stephanie Bi et al., *Teaching Intersectionality of Sexual Orientation, Gender Identity, and Race/Ethnicity in a Health Disparities Course*, THE ASS'N AM. MED. COLLS. J. OF TEACHING & LEARNING RES. 1 (2020).

[43] Angela P. Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758, 770 (2020).

[44] *Id.* at 771 (citing Black Americans and sexual minorities as examples); *see also* Kathryn Macapagal et al., *Differences in Healthcare Access, Use, and Experiences Within a Community Sample of Racially Diverse Lesbian, Gay, Bisexual, Transgender, and Questioning Emerging Adults*, 3 LESBIAN GAY BISEXUAL TRANSGENDER HEALTH 434, 435 (2016) ("sexual minority women and LGBTQ people of color report worse health status, more unmet healthcare needs, and perceived and actual discrimination or substandard care than sexual minority men and White, LGBTQ people, respectively").

[45] Samantha Artiga et al., *Health Coverage by Race and Ethnicity, 2010-2019*, KKF (July 16, 2021), https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/.

These disparities are exacerbated for LGBTQ+ racial and ethnic minorities. LGBTQ+ emerging adults (age eighteen to twenty-nine) face additional challenges in receiving healthcare; they are more likely to avoid healthcare visits and face difficulties disclosing their sexual orientation and/or gender identity due to stigma, discrimination, and social/cultural myths.[46] As an individual occupies more disadvantaged population categories, the likelihood of this person experiencing health disparities grows higher (e.g., an LGBTQ+ racial and ethnic minority who has a disability).[47]

Similarly, Harris and Pamukcu argue, the pathways through which SDOH produce health disparities also overlap and interact.[48] Recent research has found that individuals who lack the ability to vote and influence the political process are more likely to experience negative health outcomes.[49] For example, while there are multiple issues that contribute to voter suppression in Black communities, redlining—a practice by which banks denied mortgages to primarily racial and ethnic minorities in urban areas to prevent them from buying a home in certain neighborhoods—has been the most historically detrimental practice.[50] Although redlining was banned by Congress in 1968 through the passing of the Fair Housing Act, the impact of this practice is still seen today; many historically redlined communities remain significantly racially segregated and experience low homeownership rates, home values, and credit scores.[51] This example showcases the intersection of all three pathways: population (e.g., racial/ethnic minorities), place (e.g., urban areas; lack of access to desirable neighborhoods and to resources such as nutritious food, clean water, and quality healthcare), and power (e.g., voter suppression). It also highlights the need to more closely examine one of the major contributors of health disparities—discrimination.[52]

In 2003, a report published by the Institute of Medicine of the National Academies of Science, Engineering, and Medicine highlighted the equal importance of "education and training of healthcare professionals" and "enforcement of regulation and statute" in building a "comprehensive, multi-level intervention strategy to address . . . disparities in healthcare."[53] The report found strong evidence regarding "the role of bias, stereotyping,

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[46] Macapagal et al., *supra* note 44, at 434–35.

[47] Cailin O'Connor et al., *The Emergence of Intersectional Disadvantage*, 33 SOC. EPISTEMOLOGY 23 (2019).

[48] Harris & Pamukcu, *supra* note 43, at 782.

[49] Jonathan Purtle, *Felon Disenfranchisement in the United States: A Health Equality Perspective*, 103 AM. J. PUB. HEALTH 632 (2013).

[50] Khristopher J. Brooks, *Redlining Legacy: Maps are Gone, but the Problem Hasn't Disappeared*, CBS NEWS (June 12, 2020), https://www.cbsnews.com/news/redlining-what-is-history-mike-bloomberg-comments/.

[51] Emily Badger, *How Redlining's Racist Effects Lasted for Decades*, N.Y. TIMES (Aug. 24, 2017), https://www.nytimes.com/2017/08/24/upshot/how-redlinings-racist-effects-lasted-for-decades.html.

[52] Charity Scott, *Incorporating Lawyers on the Interprofessional Team to Promote Health and Health Equity*, 14 IND. HEALTH L. REV. 54 (2017).

[53] Report at 187 (Report on file with author).

prejudice, and clinical uncertainty" in healthcare services[54] and focused on discrimination in healthcare as a major contributor to health disparities.[55] Using civil rights laws and mechanisms to address discrimination can reduce disparities in SDOH, such as access to quality healthcare, education, employment, housing, transportation, and other conditions that significantly impact health. Title VI of the Civil Rights Act of 1964 and the Rehabilitation Act are two of the leading statutes that mandate nondiscrimination in federally funded programs and activities based on an individual's race, color, national origin (Title VI) or disability (Rehabilitation Act). To further understand the federal government's efforts in combatting health disparities requires a deeper look at the civil rights movement and the implementation of federal civil rights laws that promote access to improved population-level SDOH.

II. OUTLINING THE FEDERAL CIVIL RIGHTS FRAMEWORK

A. The Civil Rights Movement

At the turn of the twentieth century, the United States began to acknowledge, study, and eventually combat health disparities, beginning with race- and sex-based barriers in health outcomes. In May 1868, the American Medical Association ("AMA") held one of its most controversial meetings documented in history, in which it denied the right of qualified female, Black physicians to be admitted into the organization.[56] In 1870 and 1872, the AMA refused to seat three Black delegates at its annual meetings.[57] In response to the AMA's racial barriers, the National Medical Association was founded in 1895 to train Black physicians and study diseases disproportionately contracted by minorities.[58]

One year after the National Medical Association was established, Frederick L. Hoffman, a statistician and renowned expert on health disparities, published a troubling report entitled *Race Traits and Tendencies of the American Negro*.[59] Using statistics, eugenics theory, observation, and speculation, Hoffman concluded that the poor health status of Black individuals was due to inherent racial inferiority.[60] In 1906, W.E.B. DuBois, a prominent Black scholar, discredited Hoffman's theories, stating that the mortality of minorities would decrease with "improved sanitary condition,

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[54] Report at 178 (Report on file with author).

[55] Scott, *supra* note 52, at 58.

[56] Robert B. Baker, *The American Medical Association and Race*, 16 AM. MED. ASS'N J. ETHICS 479, 479 (2014).

[57] Harriet A. Washington, *Apology Shines Light on Racial Schism in Medicine*, N.Y. TIMES (July 29, 2008), https://www.nytimes.com/2008/07/29/health/views/29essa.html.

[58] Daryll C. Dykes, *Health Injustice and Justice in Health: The Role of Law and Public Policy in Generating, Perpetuating, and Responding to Racial and Ethnic Health Disparities Before and After the Affordable Care Act*, 41 WILLIAM MITCHEL L. REV. 1129, 1135 (2015).

[59] FREDERICK L. HOFFMAN, RACE TRAITS AND TENDENCIES OF THE AMERICAN NEGRO (1896).

[60] *Id.* at 95.

improved education, and better economic opportunities."[61] In 1944, Nobel-laureate economist Gunnar Myrdal concurred with DuBois' findings, stating:

> Medical knowledge has advanced beyond medical practice, and medical practice has advanced far beyond most people's opportunity to take advantage of it. A reduction in these lags would have tremendous consequences for the well-being and happiness of every person in the nation. Of special significance to the [minorities] is the lag of opportunity for some people to obtain the advantage of medical practices available to other people. Area for area, class for class, [minorities] cannot get the same advantages in the way of prevention and cure of disease that the whites can. There is discrimination against [minorities] in the availability . . . of medical facilities.[62]

The civil rights movement continued to gain strength in the 1950s and 1960s. Civil rights advocates pushed for social, legislative, and judicial milestones to combat disparities in health, housing, education,[63] and public accommodations.[64] Across the nation, protesters used nonviolent tactics, such as marches, sit-ins, and boycotts of businesses that perpetuated segregation.[65] They focused on equality of rights in every area of life, including the right to quality healthcare. The disenfranchisement of Black persons seeking healthcare began to shift in the early 1960s when the federal government ended "separate but equal" access to healthcare.[66]

B. Introduction to Civil Rights Laws

On June 11, 1963, in his address to the American people, President John F. Kennedy introduced a bill that would "[give] all Americans the right to be served in facilities which are open to the public—hotels, restaurants, theaters, retail stores, and similar establishments" as well as "greater protection for the right to vote."[67] The bill was known as the Civil Rights Act, a landmark legislation outlawing discrimination on the basis of race, color, religion, sex, and national origin. The bill faced strong opposition in

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[61] W. E. Burghardt DuBois, *The Health and Physique of the Negro American*, 93 AM. J. PUB. HEALTH 272, 276 (2003).

[62] GUNNAR MYRDAL, AN AMERICAN DILEMMA: THE NEGRO PROBLEM AND MODERN DEMOCRACY 171–72 (1944).

[63] Brown v. Bd. of Educ., 347 U.S. 483 (1954) (ruling that racial segregation in schools was unconstitutional).

[64] Dykes, *supra* note 58, at 1138.

[65] Cheryl Bond-Nelms, *Boycotts, Movements, and Marches*, AM. ASS'N FOR RETIRED PERSONS (Feb. 9, 2018), https://www.aarp.org/politics-society/history/info-2018/civil-rights-events-fd.html.

[66] Ruqaiijah Yearby, *Breaking the Cycle of "Unequal Treatment" with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 CONN. L. REV. 1281, 1289 (2012).

[67] President John F. Kennedy, Radio and Television Address on Civil Rights (June 11, 1963).

the House of Representatives and was the subject of a heated debate in the Senate.[68] In November 1963, President Kennedy was assassinated, and Vice President Lyndon Johnson became President.[69]

In his first address to a joint session of Congress following Kennedy's death, President Johnson stated, "[N]o memorial oration or eulogy could more eloquently honor President Kennedy's memory than the earliest possible passage of the civil rights bill for which he fought so long . . . John Kennedy's death commands what his life conveyed: that America must move forward."[70]

From its inception, President Johnson and proponents of the Civil Rights Act demonstrated their intent to use Title VI of the Act as a tool to reduce health disparities and achieve health equity. During the Senate floor debate, proponents of the bill repeatedly referenced a Fourth Circuit case, *Simkins v. Moses H. Cone Memorial Hospital*, brought by Black physicians, dentists, and patients to challenge racial segregation in a federally funded hospital under the Hill-Burton Act.[71] Under the Hill-Burton Act, Congress allowed the distribution of federal funds to racially segregated hospitals;[72] however, the Fourth Circuit held that the "separate-but-equal" language within the Hill-Burton Act was unconstitutional.[73] The case was appealed to the U.S. Supreme Court, which denied review, allowing the Fourth Circuit's conclusion that the "separate but equal doctrine" was illegal to stand, validating the nondiscrimination objectives laid out in the Civil Rights Act.[74] Senator John Pastore of Rhode Island, a major proponent of the Civil Rights Act, elaborated:

> [D]espite the effort of the Court of Appeals to strike down discrimination in the *Simkins* case, the same court was forced last week to rule again in a Wilmington, N.C., suit that a private hospital operated with public funds must desist from barring Negro physicians from staff membership. That is why we need Title VI of the Civil Rights Act—to prevent such discrimination where Federal funds are involved. Title VI intends to insure once and for all that the financial resources of the Federal Government—the commonwealth of Negro and White alike—will no longer subsidize racial discrimination.[75]

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[68] *President Johnson Signs Civil Rights Act*, HISTORY, https://www.history.com/this-day-in-history/johnson-signs-civil-rights-act (last visited Mar. 22, 2022).

[69] *Id.*

[70] President Lyndon B. Johnson, Address to a Joint Session of Congress (Nov. 27, 1963).

[71] Simkins v. Moses H. Cone Mem'l Hosp., 323 F.2d 959 (4th Cir. 1963).

[72] 42 U.S.C. § 291f (2006).

[73] *Simkins*, 323 F.2d at 969.

[74] Moses H. Cone Mem'l Hosp. v. Simkins, 376 U.S. 938 (1964).

[75] 110 CONG. REC. 7054–55 (1964).

In July 1964, Congress passed, and President Lyndon Johnson signed the Civil Rights Act, expanding its predecessors' prohibitions against discrimination based on race to include sex and religion.[76] Title VI of the Act forbids the distribution of federal funds to discriminatory programs and institutions. Section 601 of the Act declares that "[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."[77] Section 602 goes on to state that "[e]ach federal department and agency. . . is authorized and directed to effectuate the provisions of section 2000d [Section 601] of this title . . . [,]" thus giving administrative agencies the authority to promulgate regulations and establish standards of nondiscrimination consistent with the intent of the law.[78]

For the first time, civil rights advocates and public officials could rely upon a legislative mandate guaranteeing equal access to federally funded programs, which reached virtually every hospital in the United States. Prior to the Civil Rights Act, most hospitals located in the northern part of the United States were integrated, but hospitals in the south remained primarily segregated, either outright refusing admission to minorities based on race or sending them to separate, substandard facilities.[79] The national strategy to eliminate discrimination in healthcare focused on an expansive approach, using enforcement by federal agencies using the Civil Rights Act as the foundation. Subsequent to the Civil Rights Act, members of the public were now able to assert their rights directly in federal court through litigation or rely upon executive action and administrative proceedings.[80]

By 1966, over eighty-five percent of hospitals were desegregated and no longer refusing patients based on the grounds outlined under the Civil Rights Act.[81] Federal efforts to desegregate hospitals followed the flow of federal dollars, first to facilities operated by the federal government, then to medical schools, and finally to the vast majority of acute care hospitals through the implementation of Medicare.[82] Within a few years, overt racial discrimination diminished within publicly funded programs and services; however, less obvious discriminatory actions based on race as well as other traits remained, forcing Congress to take action.[83] Following the Civil Rights Act, Congress enacted foundational civil rights laws that extend protections

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[76] George Rutherglen, *Private Rights and Private Actions: The Legacy of Civil Rights in the Enforcement of Title VII*, 95 B.U. L. REV. 733, 743 (2015); 42 U.S.C. § 2000e-2 (1964).

[77] 42 U.S.C. § 2000d (1964); Civil Rights Act of 1964, Pub. L. No. 88-352, § 601, 78 Stat. 252.

[78] 42 U.S.C. § 2000d-1 (1964); Civil Rights Act of 1964, Pub. L. 88-352, § 602, 78 Stat. 252.

[79] P. Preston Reynolds, *The Federal Government's Use of Title VI and Medicare to Racially Integrate Hospitals in the United States, 1963 Through 1967*, 87 AM. J. PUB. HEALTH 1850, 1850 (1997).

[80] Rutherglen, *supra* note 76, at 743; 42 U.S.C. § 2000a-3; 42 U.S.C. § 2000a-5; 42 U.S.C. § 2000e-5; 42 U.S.C. § 2000e-6.

[81] Reynolds, *supra* note 79, at 1855.

[82] David Barton Smith, *Racial and Ethnic Health Disparities and the Unfinished Civil Rights Agenda*, 24 HEALTH AFFS. 317 (2005).

[83] Sara Rosenbaum & Sara Schmucker, *Viewing Health Equity Through a Legal Lens: Title VI of the 1964 Civil Rights Act*, 42 J. HEALTH POL., POL'Y, & L. 771 (2017).

to individuals based on disability, age, native language, familial status, and other bases.

TABLE 2.

Law	Year Enacted	Protected Population(s)	Requirements
Civil Rights Act (Title VI)	1964	All individuals	Prohibits discrimination based on race, color, or national origin in federally funded programs and activities.[84] Funding recipients must take reasonable steps necessary to provide persons with limited English proficiency a "meaningful opportunity to participate."[85]
Title IX of the Education Amendments	1972	All individuals	Prohibits sex discrimination in education programs and activities conducted by federally funded entities.[86] These includes traditional educational institutions (e.g., colleges and universities) as well as HHS funded educational programs, such as research and occupational training.[87]
Rehabilitation Act	1973	People with disabilities	Act broadly prohibits discrimination by federal agencies and its funding recipients against otherwise qualified individuals based on disability.[88] Section 508 of the Rehabilitation Act requires federal agencies

[84] 42 U.S.C. § 2000d.
[85] Lau v. Nichols, 414 U.S. 563, 568 (1974).
[86] 20 U.S.C. § 1681.
[87] *Id.*
[88] 29 U.S.C. § 701.

			to make their electronic and information technology, such as their websites and other online materials, accessible to people with disabilities.[89]
Age Discrimination Act	1975	Older adults	Prohibits discrimination based on age in federally funded programs or activities.[90]
Americans with Disabilities Act ("ADA")	1990	People with disabilities	Expands the Rehabilitation Act's reach beyond federally funded programs to all businesses and services available to the general public, including physicians in private practice and both public and private insurers. Title I of the ADA covers employment and mandates employers to reasonably accommodate known physical or mental limitations of an otherwise qualified applicant or employee with a disability, unless it would impose an undue hardship on the operation of the employer's business.[91] Title II of the ADA covers services, programs, and activities operated by State and local government entities.[92] Title III of the ADA prohibits discrimination based on disability in public

[89] 29 U.S.C. § 794d.
[90] 42 U.S.C. § 6101.
[91] 42 U.S.C. §§ 12111–12117.
[92] 42 U.S.C. §§ 12131–12165.

			accommodations operated by private entities, such as places of lodging, entertainment, public gathering, education, exercise, restaurants, and other facilities.[93] Title IV focuses on telecommunications to ensure functionally equivalent services for people with disabilities[94] and Title V covers miscellaneous provisions, including a prohibition against retaliation or coercion against individuals who exercise their rights under the ADA.[95]
Section 1557 of the Affordable Care Act	2016	All individuals	Prohibits discrimination in health programs and activities (both federally conducted and funded) based on race, color, national origin, sex, disability, and age.[96]

For many of these civil rights statutes, federal departments have their own implementing regulations that provide a framework for how funding recipients can comply with the laws and how departments will enforce their requirements.[97] In addition, Executive Orders—or directives published by the U.S. President—have played a key role in the civil rights movement under multiple presidencies.[98] In 1957, after

[93] 42 U.S.C. §§ 12181–12189.
[94] 47 U.S.C. § 225.
[95] 42 U.S.C. §§ 12201–12213.
[96] 42 U.S.C. § 18116.
[97] For example, Title VI of the Civil Rights of 1964 has been implemented by the Department of Justice, 28 C.F.R. § 42.101, Health & Human Services, 45 C.F.R. § 80, the Department of Education, 34 C.F.R. § 100, the Department of Labor, 29 C.F.R. § 31, and other federal departments.
[98] *What is an Executive Order?*, AM. BAR ASS'N (Jan. 25, 2021), https://www.americanbar.org/groups/public_education/publications/teaching-legal-docs/what-is-an-executive-order-/.

the U.S. Supreme Court ruled in *Brown v. Board of Education*[99] that segregated schools were "inherently unequal" and ordered that U.S. public schools be desegregated "with all deliberate speed,"[100] President Eisenhower supplemented this ruling with an Executive Order directing the Arkansas National Guard to ensure the safety of nine Black high school students at the center of an integration crisis in Little Rock, Arkansas.[101] In the following decades, Presidents Kennedy and Johnson used Executive Orders to publish affirmative action and equal employment opportunity actions.[102] As discussed later in this article, President Clinton issued an Executive Order requiring federal agencies to work to ensure that funding recipients provide meaningful access to their limited English proficient ("LEP") applicants and beneficiaries.[103] Under the current Administration, President Biden has used multiple Executive Orders to signal and lead significant efforts to further civil rights protections and to promote health equity, specifically with regard to race, color, national origin, sexual orientation, and gender identity.[104]

To supplement these efforts, there is a growing consensus among federal agencies and Congress that "since the key drivers of good health lie in the social determinants of health, [federal agencies] need to look 'upstream' and intervene on the conditions of life in our homes, neighborhoods, schools, and workplaces."[105] To achieve health equity, federal departments must not only enforce civil rights laws, but also study and establish policies and practices that create

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[99] Brown v. Bd. of Educ., 347 U.S. 483, 484 (1954).

[100] *History – Brown v. Board of Education Re-enactment*, U.S. CTS., https://www.uscourts.gov/educational-resources/educational-activities/history-brown-v-board-education-re-enactment (last visited Mar. 9, 2022).

[101] *Civil Rights: The Little Rock School Integration Crisis*, DWIGHT D. EISENHOWER PRESIDENTIAL LIBR., MUSEUM, & BOYHOOD HOME, https://www.eisenhowerlibrary.gov/research/online-documents/civil-rights-little-rock-school-integration-crisis (last visited Mar. 9, 2022).

[102] *Executive Orders 101: What Are They and How Do Presidents Use Them?*, NAT'L CONST. CTR. (Jan. 23, 2017), https://constitutioncenter.org/blog/executive-orders-101-what-are-they-and-how-do-presidents-use-them/.

[103] Exec. Order No. 13166, 3 C.F.R. 50121 (2000).

[104] *See* Exec. Order No. 13,988, 86 Fed. Reg. 7023 (2021). Among other things, the Order directs agencies to "consider whether to revise, suspend, or rescind such agency actions [regulations, guidance documents, policies, programs, or other agency actions], or promulgate new agency actions, as necessary to fully implement statutes that prohibit sex discrimination and the policy set forth in section 1 of this order" (prohibit discrimination on the basis of sex, including sexual orientation and gender identification); Exec. Order No. 13,985, 86 F.R. 7009 (2021). Among other things, the Order requires all agency heads to study methods for assessing whether agency policies and actions create or exacerbate barriers to full and equal participation by all eligible individuals.

[105] David R. Williams & Valerie Purdie-Vaughns, *Needed Interventions to Reduce Racial/Ethnic Disparities in Health*, 41 J. HEALTH POL., POL'Y & L., 627, 629 (2016).

positive social and economic conditions accessible by all individuals.[106]

III. A MULTIFACETED AND PROACTIVE FEDERAL APPROACH TO ACHIEVE HEALTH EQUITY

> "[D]iscrimination is a root cause of health disparities, and a comprehensive strategy to eliminate disparities must incorporate a strong civil rights component."[107]

Due to the persistent and pervasive health disparities that continue to exist in the United States today, Congress has charged federal departments to take a multifaceted approach to reduce health disparities and achieve health equity.[108] One of the root causes of health disparities is discrimination, which is prohibited by federal civil rights laws on protected bases such as race, color, national origin, sex, age, and disability. In prohibiting federal agencies and recipients of federal funds from engaging in differential treatment (whether intentional or unintentional) of certain individuals or groups of people, federal civil rights laws promote access by underserved populations to improved population-level SDOH, such as safe and affordable housing, high-level higher education, and availability of quality health care services, through enforcement and proactive education.[109] When a SDOH is improved in a population, so is population health.[110]

HHS, alongside other federal departments, uses civil rights mechanisms to both educate funding recipients and enforce against discriminatory practices in federally funded programs and activities. Given its financial footprint, HHS's efforts are especially critical in providing baseline support to eliminate health disparities and achieve health equity across all improved SDOH. HHS's budget accounts for almost one out of every four federal dollars and its eleven operating divisions administer more grant dollars than all other federal agencies combined.[111] In fiscal year ("FY") 2021, HHS awarded over 125,000 grants, totaling over $800 billion (see *Figure 1*).[112]

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[106] *Social Determinants of Health*, HEALTHYPEOPLE.GOV, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health (last visited Mar. 9, 2022).

[107] INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 628 (Brian D. Smedley et al. eds., 2003) (quoting Tom Perez, the former Assistant Attorney General for Civil Rights at the U.S. Department of Justice).

[108] *Id.* at 455.

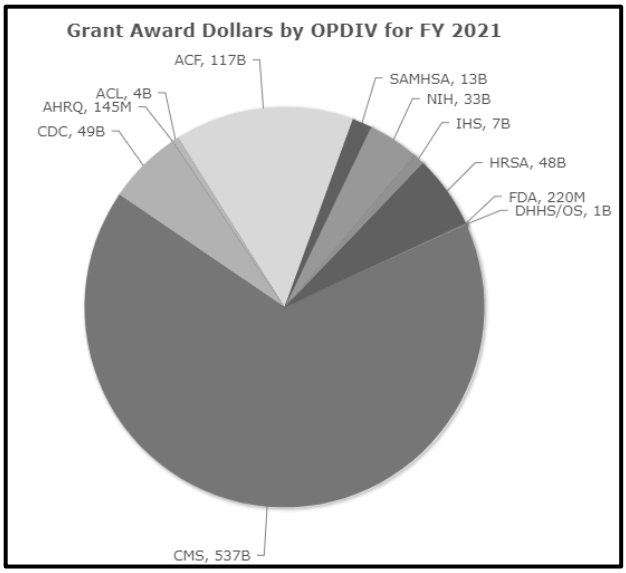
[109] HEALTHYPEOPLE.GOV, *supra* note 106.

[110] Robert A. Hahn, Benedict I. Truman & David R. Williams, *Civil Rights as Determinants of Public Health and Racial and Ethnic Health Equity: Health Care, Education, Employment, and Housing in the United States*, 4 SOC. SCI. & MED. - POPULATION HEALTH 17, 20 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5730086.

[111] *Introduction: About HHS*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/about/strategic-plan/introduction/index.html (last visited Mar. 9, 2022).

[112] *Grants by OPDIV*, TRACKING ACCOUNTABILITY IN GOV'T GRANT SYS., https://taggs.hhs.gov/ReportsGrants/GrantsByOPDIV (last visited June 15, 2022).

FIGURE 1.



Recipients of HHS funds include hospitals, health centers, extended care facilities, family and children programs, alcohol and drug treatment programs, public assistance agencies, adoption and foster care programs, and senior citizen programs.[113] In addition to administrative requirements, HHS funding recipients are obligated to comply with civil rights laws prohibiting discrimination on the basis of race, color, national origin, disability, sex, age, and other protected bases.[114]

HHS has eleven operating divisions that oversee a wide variety of health and human services, and encourages open communication channels between the government, federally funded programs, and protected populations to promote accessibility to quality healthcare.[115] Some agencies award grants specifically focused on reaching populations that are underserved. For example, over the last ten years, the Indian Health Service awarded multiple grants for accessible and affordable HIV/AIDS services to at-risk Native American communities in the Southwest region.[116] The National Institutes of Health ("NIH") has awarded millions of dollars to

[113] *Mission and Vision*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.grants.gov/learn-grants/grant-making-agencies/department-of-health-and-human-services.html (last visited Mar. 9, 2022).

[114] *Civil Rights for Individuals and Advocates*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/civil-rights/for-individuals/index.html (last visited Mar. 9, 2022).

[115] *HHS Agencies & Offices*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/about/agencies/hhs-agencies-and-offices/index.html (last visited Mar. 9, 2022).

[116] *To Offer Accessible, Affordable HIV/AIDS Services to At-Risk Urban, Native Americans in Flagstaff, Coconino County, Arizona.* U.S. DEP'T OF HEALTH & HUM. SERVS., https://taggs.hhs.gov/Detail/AwardDetail?arg_AwardNum=H721IHS0002&arg_ProgOfficeCode=3 (last visited Mar. 10, 2022).

recipients developing software to promote accessibility by people who are blind or have low vision.[117] The Administration for Community Living ("ACL") awards more than one billion dollars in grants to provide services, conduct research, and develop innovative approaches to support older adults and people with disabilities.[118] Other funding agencies, such as HRSA, more broadly focus on addressing health disparities for populations that are underserved. In FY 2019, HRSA awarded nearly $10 billion in grants[119] specifically to improve access to quality healthcare by people who are geographically isolated and those who are economically or medically vulnerable, such as people with HIV/AIDS, pregnant people, rural communities, and other populations that are underserved.[120]

Given this article's focus on HHS activities, this section discusses how HHS—through its Office for Civil Rights—uses enforcement procedures to address specific instances of discrimination amongst its funding recipients. Congress charged the federal government with enforcing federal civil rights laws that protect individuals from discrimination on the bases of race, color, national origin, religion, sex, disability, and age across a broad range of areas. Each major federal department has delegated authority to an internal office to enforce its civil rights regulations by investigating complaints, conducting compliance reviews, or using other forms of corrective action.[121]

This section will then move into general limitations of civil rights enforcement and evaluate how federal funding agencies can complement civil rights compliance efforts. HRSA will be used as a case study to analyze and discuss federal efforts focusing on prevention and proactive education as critical supplements of health reform and civil rights coordination. Through targeted grants, funding agencies assist populations that are underserved and beneficiaries by encouraging applicants to actively plan on how they can maximize the reach of the funding and meet their civil rights obligations. HRSA grantees, like all recipients of federal funds, must comply with federal civil rights laws that promote accessibility to healthcare and prohibit discrimination based on race, color, national origin, disability, age, sex, and religion.[122] Through OCRDI, HRSA continuously provides consultations and technical assistance to its funding recipients on how to meet their civil rights obligations to help prevent potential discrimination,

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[117] *Designing Visually Accessible Spaces*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://taggs.hhs.gov/Detail/AwardDetail?arg_AwardNum=R01EY017835&arg_ProgOfficeCode=124 (last visited Mar. 9, 2022); Gordon E. Legge, *Designing Visually Accessible Spaces*, NAT'L INST. OF HEALTH, https://grantome.com/grant/NIH/R01-EY017835-06A1 (last visited Mar. 9, 2022).

[118] *Grants*, ADMIN. FOR CMTY. LIVING, https://acl.gov/grants (Sept. 15, 2021).

[119] *Number of Grant Awards by OPDIV for FY 2020*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://taggs.hhs.gov/ReportsGrants/GrantsByOPDIV (last visited Mar. 10, 2022).

[120] *HRSA Programs*, HEALTH RES. & SERVS. ADMIN. (2021), https://www.hrsa.gov/sites/default/files/hrsa/about/hrsa-agency-overview.pdf.

[121] *Civil Rights Office of Federal Agencies*, U.S. DEP'T OF JUST., https://www.justice.gov/crt/fcs/Agency-OCR-Offices (last visited Mar. 9, 2022).

[122] *Office of Civil Rights, Diversity and Inclusion*, HEALTH RES. & SERVS. ADMIN. (2021), https://www.hrsa.gov/about/organization/bureaus/ocrdi.

correct misunderstandings about accessibility, and equip recipients with strategies on how to apply the law in their programs.

This section will conclude by providing general recommendations for federal funding agencies to help "eliminate health disparities, achieve health equity, [and] create social, physical, and economic environments that promote attaining the full potential for health and well-being for all."[123]

A. Overview of Civil Rights Enforcement and Litigation

For the last six decades, Congress has expanded the federal government's role in its fight against discrimination with each major piece of civil rights legislation. Internal civil rights offices were established to ensure federal funding recipients' compliance with federal civil rights laws. Some civil rights statutes, such as Title VI of the Civil Rights Act, apply across major federal departments, each of which have each issued nondiscrimination regulations for the programs they fund according to Title VI's requirements.[124] Depending on the law, the specific jurisdiction and duties of civil rights enforcement offices vary, but generally include investigating civil rights complaints, monitoring compliance by federally funded and other covered entities, and issuing guidance or other policy documents.[125]

The HHS Office for Civil Rights ("OCR") retains enforcement authority over Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, the Age Discrimination Act, Section 1557 of the Affordable Care Act, and other federal laws that prohibit discrimination by providers of healthcare and social services.[126] Members of the public who experience discrimination by a funding recipient may initiate the civil rights enforcement process by filing a complaint with OCR.[127] OCR's enforcement mechanisms include conducting investigations of funding recipients based on complaints[128] and initiating periodic compliance reviews to determine whether a recipient of HHS funding is complying with federal civil rights laws.[129]

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[123] *Healthy People 2030 Framework*, HEALTH.GOV., https://health.gov/healthypeople/about/healthy-people-2030-framework (last visited Mar. 9, 2022).

[124] 42 U.S.C. §§ 2000a-h(6).

[125] *Are Rights a Reality: Evaluating Federal Civil Rights Enforcement*, U.S. COMM'N ON C.R. (2019), https://www.usccr.gov/pubs/2019/11-21-Are-Rights-a-Reality.pdf.

[126] *Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority*, CTR. FOR MEDICARE & MEDICAID SERVS. (Jun. 19, 2020), https://www.federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

[127] *What to Expect: How OCR Investigates a Civil Rights Complaint*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/civil-rights/filing-a-complaint/what-to-expect/index.html (last visited Mar. 9, 2022).

[128] 45 C.F.R. § 80.7(b) (1964); 45 C.F.R § 83.20 (1975); 45 C.F.R § 84.61 (1977); 45 C.F.R § 85.61(d) (2022); 45 C.F.R § 86.71 (2022); 45 C.F.R. § 88.2 (2019); 45 C.F.R. § 91.42 (2022).

[129] 45 C.F.R. §§ 80.7(a), (c) (2022) (regarding proactive compliance review leading to investigation, which can lead to enforcement actions for noncompliance at the end of the process).

In 2017, HHS OCR reports that it received 30,166 civil rights complaints against HHS funding recipients and that the number is growing.[130] OCR attempts to resolve noncompliance through various means, such as a voluntary agreement between the agency and funding recipient, providing technical assistance to the recipient, or another form of corrective action.[131] In some instances, OCR works with the funding agency to bring the recipient into compliance.[132] If OCR issues a violation finding and the funding recipient refuses to come into compliance by taking corrective action, the matter is referred to the HHS Office of General Counsel for administrative enforcement (litigation) and an administrative law judge may order termination of funding.[133] However, this situation is rare given OCR's primary practice is helping recipients achieve compliance with civil rights laws and, as a result, the vast majority of complaints are resolved through voluntary efforts.[134]

Outside of utilizing federal civil rights enforcement mechanisms, members of the public may choose to enforce a private right of action by suing the discriminatory entity in federal court, depending on the law.[135] Under some civil rights laws,[136] the legal system has recognized the effect of discrimination on an individual's mental health by awarding monetary damages to victims for emotional distress and psychiatric harms, such as humiliation, depression, and post-traumatic stress.[137]

Disparate impact claims allow plaintiffs to extend claims beyond intentional discrimination; instead, a plaintiff may make a prima facie showing of discrimination by proving that a policy or practice has an adverse impact on a protected group, thus creating a presumption of discrimination.[138] The integration of hospitals and healthcare facilities in the 1960s addressed the most overt forms of discrimination; unfortunately, health disparities and de facto segregation, or segregation by practice, has

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[130] U.S. COMM'N ON C.R., ARE RIGHTS A REALITY? EVALUATING FEDERAL CIVIL RIGHTS ENFORCEMENT 206 (2019), https://www.usccr.gov/files/pubs/2019/11-21-Are-Rights-a-Reality.pdf.

[131] U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 127.

[132] 2011 Conscience Rule, 45 C.F.R § 88.1 (2022).

[133] U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 127.

[134] U.S. DEP'T OF HEALTH & HUM. SERVS., GUIDANCE TO FEDERAL FINANCIAL ASSISTANCE RECIPIENTS REGARDING TITLE VI PROHIBITION AGAINST NATIONAL ORIGIN DISCRIMINATION AFFECTING LIMITED ENGLISH PROFICIENT PERSONS (July 26, 2019), https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-vi/index.html.

[135] For example, Title IX of the Education Amendments permits a private right of action (20 U.S.C. § 1683 (judicial review)), as well as the Rehabilitation Act (29 U.S.C. § 794(a)(2) (remedies and attorney fees)).

[136] For example, the Fair Housing Act (42 U.S.C. §§ 3601–19).

[137] Timothy J. Moran, *Punitive Damages in Fair Housing Litigation: Ending Unwise Restrictions on a Necessary Remedy*, 36 HARV. C.R. C.L. L. REV., 279, 290–91 (2001); Margalynne J. Armstrong, *Desegregation Through Private Litigation: Using Equitable Remedies to Achieve the Purposes of the Fair Housing Act*, 64 TEMP. L. REV. 909, 924 (1991); Larry R. Rogers & Kelly N. Kalus, *From One Dollar to $2.4 Million: Narrowing the Spectrum of Damage Awards in Fair Housing Cases Through Basic Tort Litigation Tactics*, 26 J. MARSHALL L. REV. 29, 30 (1991).

[138] Alexander v. Sandoval, 532 U.S. 275 (2001).

survived.[139] For instance, in 2011, several hospital systems in New York separated patients seeking cardiac and endocrine treatment according to their source of payment; patients relying on public assistance received lower quality health care than patients using private health insurance. Specifically, Medicaid beneficiaries received services at cardiology and endocrinology clinics, where they do not receive care comparable to that received by privately insured patients seen in faculty practices.[140] Because patients using public assistance were disproportionately Black or Latino, the hospitals' separation policy disparately and negatively impacted these minority groups.[141]

Additionally, recent studies have shown that physicians who treat minority patients are less likely to be board certified and more likely to lack access to quality medical equipment, compared to physicians treating White patients.[142] Researchers have determined that bias, discrimination, and stereotyping may cause providers to treat patients differently based on race or another federally protected status.[143] Providers may also not understand their civil rights obligations and, accordingly, may be unintentionally discriminating against patients. For example, making their facilities physically accessible for people with mobility limitations or providing translated materials to a Spanish-speaking patient may be required under some circumstances. It may also be the case that providers are aware of their obligations, but do not know how to comply with federal civil rights laws using the funds that are available to them.

Modern forms of discrimination require complex interventions that cannot be resolved by enforcement or litigation alone. The historical civil rights movement and trends in health disparities assist us in determining how to address modern forms of discrimination in healthcare and work to achieve health equity. The civil rights movement used numerous strategies, such as litigation, the passage of civil rights legislation, and its subsequent implementation by federal agencies through outreach and education, to dismantle de jure segregation, otherwise known as segregation by law. Today, as mandated by Congress, the federal government continues to use multiple strategies to combat discrimination in health, alleviate health disparities, and achieve health equity through civil rights laws, which will be discussed in the next section.

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[139] Amitabh Chandra, et al., *Challenges to Reducing Discrimination and Health Inequity Through Existing Civil Rights Laws*, 36 HEALTH AFFS. 1041 (2017).

[140] Complaint at 21, 23–24, Bronx Health Reach v. New York Presbyterian et al. (2008), https://www.nylpi.org/images/FE/chain234siteType8/site203/client/COMPLAINT-FINAL-FULL.pdf.

[141] Adrian D. Samuels & Mariah L. Cole, *Utilizing Title VI as a Means to Eradicate Health Discrimination*, 10 J. HEALTH DISPARITIES RSCH. & PRAC. 30, 32 (2017).

[142] Chandra, *supra* note 139, at 1041.

[143] *Id.*

B. Limitations of Enforcement

In addition to limited financial resources and staffing, enforcement efforts can include difficulties establishing proof, obtaining effective remedies, and overcoming legal challenges to disparate impact complaints.[144] Furthermore, as discussed in the previous section, while disparate treatment—or intentional discrimination—is more straightforward to establish, disparate impact discrimination—a less overt form of discrimination—focuses on the consequences of a funding recipient's practices rather than the motivation. It occurs when a recipient has a facially neutral policy or practice that has a disproportionate and adverse effect on members of a group that are underserved, such as Black individuals, as compared to individuals of a different race.[145] The same analysis applies to people with disabilities.[146] Common examples include a hospital's decision to limit its number of Medicaid beds, relocate to a wealthier neighborhood, or refuse to participate in the Medicaid program.[147]

Cases under the HHS Title VI regulation also include discrimination against individuals who are limited English proficient who cannot access healthcare services for reasons such as a lack of language assistance services, including a qualified professional interpreter to communicate with a physician or translated materials to understand discharge directions. LEP cases may be argued using a disparate impact analysis; unfortunately, "numbers are at the heart" of a disparate impact case.[148] Statistical evidence is heavily relied upon in disparate impact cases to prove that not "just a single" or "very few" individuals were impacted by a funding recipient's policy or practice.[149] Additionally, private individuals may not file complaints of disparate impact discrimination based on race, color, or national origin in federal court under Title VI; therefore, the role of HHS and its funding components for ensuring recipients of HHS funds comply with Title VI is especially critical.

In *Alexander v. Sandoval*, the Supreme Court foreclosed private rights of action alleging disparate impact discrimination under the Title VI regulation.[150] Before the Supreme Court's ruling, federal agencies relied upon a dual enforcement system in which agencies and private individuals shared the burden of enforcing Title VI's disparate impact regulations; now relief for disparate impact claims under Title VI may be achieved only through federal administrative enforcement processes.[151]

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[144] Rosenbaum & Schmucker, *supra* note 83, at 771.

[145] *See* 28 C.F.R. § 42.104(b)(2) (2022); 45 C.F.R. § 80.3(b)(2) (2022).

[146] Under 504 (Alexander v. Choate, 469 U.S. 287 (1985)), and 1557 for tbl.6, 504, and tbl.9.

[147] Sarah G. Steege, *Finding a Cure in the Courts: A Private Right of Action for Disparate Impact in Health Care*, 16 MICH. J. RACE & L. 439, 443 (2011).

[148] Lau v. Nichols, 414 U.S. 563, 572 (1974) (Blackmun, J., concurring).

[149] *Id.*

[150] Alexander v. Sandoval, 532 U.S. 275 (2001); Rosenbaum & Schmucker, *supra* note 83, at 782.

[151] Jessica Rubin-Wills, *Language Access Advocacy After* Sandoval*: A Case Study of Administrative Enforcement Outside the Shadow of Judicial Review*, 36 N.Y.U. REV. L. & SOC. CHANGE 465, 485–86 (2012).

Disparate treatment LEP cases can still be brought to court using a private right of action to enforce Section 601 of Title VI; however, federal courts have set a high standard in proving intentional discrimination, requiring plaintiffs to show that the defendant's action was taken with a discriminatory motive.[152] Because LEP cases typically focus on a funding recipient's failure to provide certain language assistance services, such as interpretation or translation, this increases the difficulty for plaintiffs to show discriminatory motive when the plaintiff is challenging inaction rather than action.[153]

Despite *Alexander v. Sandoval*, individuals can continue to use private litigation for disability discrimination claims of disparate impact under Section 504 of the Rehabilitation Act.[154] The Supreme Court allowed this approach in *Alexander v. Choate*,[155] analyzing whether Tennessee's reduction in the number of annual inpatient hospital days covered by Medicaid caused a disparate and negative impact on people with disabilities under Section 504.[156]

Alexander v. Sandoval eliminated one avenue available to private litigants to achieve relief for discrimination based on race, color, or national origin.[157] Nonetheless, in addition to their enforcement authority, federal departments impact health disparities through a variety of preventative methods to remove discriminatory barriers to federally funded services and benefits such as: providing technical assistance, education, and outreach, and managing a compliance review system for ensuring recipients are operating in compliance with the law.[158] HHS has and continues to use its civil rights authorities to provide education, outreach, monitoring, and other proactive methods to help funding recipients prevent modern forms of discrimination in healthcare.

C. Federal Funding Agencies as Promoters of Health Equity and Civil Rights

> "I will prevent disease whenever I can, for prevention is preferable to cure."[159]

Congress charged federal departments to promote positive health outcomes through wide-scale efforts, such as preventing discrimination and reducing health disparities in SDOH, including employment, education,

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[152] *Id.* at 480.
[153] *Id.* at 482.
[154] Steege, *supra* note 147, at 468.
[155] Alexander v. Choate, 469 U.S. 287 (1985).
[156] Steege, *supra* note 147, at 449.
[157] Rosenbaum & Schmucker, *supra* note 83, at 782.
[158] U.S. COMM'N ON C.R., ARE RIGHTS A REALITY?: EVALUATING FEDERAL CIVIL RIGHTS ENFORCEMENT 16 (2019).
[159] Louis Lasagna, *The Hippocratic Oath: Modern Version*, PBS: NOVA, https://www.pbs.org/wgbh/nova/doctors/oath_modern.html (last visited Mar. 10, 2022) (quoting the 1964 Revised Hippocratic Oath).

healthcare, transportation, and other conditions.[160] Health is determined in part by the conditions in which we live, work, learn, and play.[161] In recognition of this, the federal government's focus on studying health disparities has increased over the last decade. Since 2003, the HHS Agency for Healthcare Research and Quality has issued yearly National Health Disparities Reports, which document trends related to access to care, effective treatment, healthy living, and person-centered care.[162] Additionally, the Healthy People Initiative, managed by HHS, sets out goals and objectives for each decade (currently 2020–2030), including an overarching goal to "eliminate health disparities, achieve health equity, . . . [and c]reate social, physical, and economic environments that promote attaining the full potential for health and well-being for all."[163]

Access to quality health care services and other SDOH provide opportunities to create a healthy population for all individuals, regardless of race, sex, disability status, or other federally protected bases. To ensure equal access to care and prevent discrimination in healthcare, major federal departments use civil rights laws as a tool to establish, enforce, and educate funding recipients on federal nondiscrimination standards, and how to administer their programs and services in a manner that promotes equality.

Civil rights enforcement offices are often isolated from day-to-day administrative authority over federal spending.[164] Given the magnitude of health disparities and the vast number of positive SDOH that influence health outcomes, there is a need for federal funding agencies to assist recipients of their funds with developing tailored approaches to comply with their civil rights laws.[165] HHS demonstrates how parallel efforts between its civil rights enforcement office and funding agencies can address the larger

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[160] *See* Civil Rights Act of 1964, Pub. L. No. 88-352, §601, 78 Stat. 252, 252 (codified as amended at 42 U.S.C. § 2000d). Rehabilitation Act of 1973, Pub. L. No. 93-112, § 504, 87 Stat. 355, 394 (codified as amended at 29 U.S.C. § 794); Education Amendments of 1972, Pub. L. No. 92-318, Title IX, 86 Stat. 373 (codified as amended at 20 U.S.C. §§ 1681–1688); Age Discrimination Act of 1975, Pub. L. No. 94-135, 89 Stat. 713 (codified as amended at 42 U.S.C. §§ 6101–6107); Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (codified as amended in scattered sections of 42 U.S.C. Ch. 126); and Fair Housing Act, Pub. L. No. 90-284, 82 Stat. 73 (1968) (codified as amended in scattered sections of 42 U.S.C. Ch. 45). Brooks, *supra* note 50.

[161] OFF. OF DISEASE PREVENTION & HEALTH PROMOTION, *Social Detriments of Health*, HEALTHYPEOPLE (Feb. 6, 2022), https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.

[162] AGENCY FOR HEALTHCARE RSCH. & QUALITY, NAT'L HEALTHCARE QUALITY & DISPARITIES REP. 1 (2021).

[163] U.S. DEP'T OF HEALTH & HUM. SERVS., *Healthy People 2030 Framework*, OFF. OF DISEASE PREVENTION & HEALTH PROMOTION, https://health.gov/healthypeople/about/healthy-people-2030-framework (last visited Mar. 14, 2022).

[164] Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of* Alexander v. Sandoval, 3 YALE J. HEALTH POL'Y, L. & ETHICS 215, 246 (2003).

[165] *Id.* To strengthen enforcement efforts, "the task of forcing large interests to confront and remedy the [] harms that can flow from facially neutral practices is surely best achieved through concerted action by government agencies [such as funding agencies] which can use their spending powers to generate systemic and structural changes." *Id.* at 245–46.

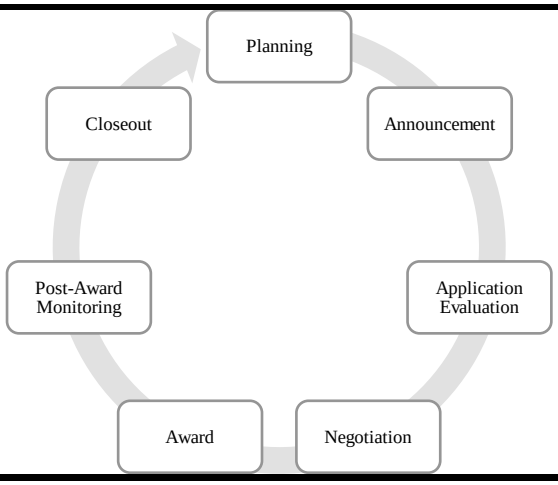
issue of health equity by helping recipients achieve compliance with federal civil rights laws through guidance, technical assistance, and outreach.

HRSA will be used as a case study to analyze how it as a funding agency employs education around proactive nondiscrimination measures as a critical part of health reform and civil rights advocacy. HRSA, through its OCRDI uses civil rights laws to educate funding recipients on their civil rights obligations to ensure compliance with federal law, advance health equity, and promote accessibility to HRSA conducted and assisted programs.[166]

The initiatives adopted by HRSA showcase how federal outreach, technical assistance, and other strategies outside of civil rights enforcement can address potential discrimination and help advance health equity. This is demonstrated by HRSA's efforts to promote compliance with civil rights laws through the grants process, planning, accessibility consultations, and technical assistance.

1. Grants Lifecycle

FIGURE 2.



Grants are used by many agencies in the federal government as a financial assistance tool to fund projects, such as innovative research, data collection, clinical programs, or other activities that benefit the general public.[167]

The grant lifecycle includes planning for and announcing the funding opportunity, applying for the grant, making award decisions, successfully implementing the award, monitoring, and closing out the lifecycle (see *Figure 2*). These specific actions along the lifecycle are grouped into three

[166] *About HRSA*, U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH RES. & SERVS. ADMIN. (2021), https://www.hrsa.gov/about/index.html.

[167] *What is a Grant?*, GRANTS.GOV (Feb. 7, 2017), https://grantsgovprod.wordpress.com/2017/02/07/new-series-what-is-a-grant/.

main phases—the pre-award phase, the award phase, and the post-award phase.[168] This section will go into further detail about each phase and what interventions HRSA utilizes to prevent discrimination and promote accessibility by all individuals receiving health care services funded by HRSA.

2. Pre-award phase: Planning, Announcement, Application Evaluation, Negotiation

The pre-award phase represents the beginning of the grant lifecycle, which includes announcing opportunities and reviewing applications. Awarding agencies must prepare and publish a Notice of Funding Opportunity ("NOFO") announcement based on authorizing legislation and the agency's budget. A NOFO includes all the relevant information and requirements for an applicant to assess their eligibility, competency, and interest in the funding opportunity.[169] Once the application submission deadline passes, the awarding agency reviews the applications for their technical and programmatic quality, and competency. "Federal agencies also conduct a cost analysis, reviewing each line item and the overall proposed budget," as well as an assessment of an applicant's financial risk and its possible impact on program performance.[170]

Funding agencies may use NOFOs to encourage or require applicants to incorporate certain services or expenses into their work plans and budgets that can promote access by populations that are underserved to the funded program. HRSA, as part of their NOFOs, includes a section on accessibility provisions and nondiscrimination requirements, stating, "Federal funding recipients must comply with applicable federal civil rights laws. HRSA supports its recipients in preventing discrimination, reducing barriers to care, and promoting health equity" followed by a link to HRSA OCRDI's website.[171] OCRDI's website is regularly updated with plain language resources for HRSA funding recipients on civil rights obligations and provides OCRDI's contact information for further inquiries.[172]

In addition to a general statement on civil rights obligations, funding agencies may choose to specify accessibility services that would be necessary to ensure nondiscrimination in certain programs. For example,

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[168] *The Grant Lifecycle*, GRANTS.GOV, https://www.grants.gov/learn-grants/grants-101/grant-lifecycle.html (last visited Mar. 14, 2022).

[169] *Pre-Award Phase*, GRANTS.GOV, https://www.grants.gov/web/grants/learn-grants/grants-101/pre-award-phase.html (last visited Mar. 10, 2022).

[170] *Id.*

[171] *See* U.S. DEP'T OF HEALTH & HUM. SERVS., *View Grant Opportunity: HRSA-22-082 Sudden Unexpected Infant Death Prevention Department of Health and Human Services Health Resources and Services Administration*, GRANTS.GOV (Nov. 5, 2021), https://www.grants.gov/web/grants/view-opportunity.html?oppId=334390; *see also* U.S. DEP'T OF HEALTH & HUM. SERVS., *View Grant Opportunity: HRSA-22-058 Rural Veterans Health Access Program Department of Health and Human Services Health Resources and Services Administration*, GRANTS.GOV (Sept. 9, 2021), https://www.grants.gov/web/grants/view-opportunity.html?oppId=334414.

[172] *Office of Civil Rights, Diversity & Inclusion*, *supra* note 122.

NOFOs under HRSA's Early Hearing Detection and Intervention program state that the funding agency expects applicants to "[i]nclude the cost of access accommodations as part of [the recipient's] project's budget [which may include] language interpreters; plain language and health literate print materials in alternate formats; and cultural/linguistic competence modifications such as use of . . . translation or interpretation services[.]"[173]

As a grant-making agency, HRSA funds programs to improve health and achieve health equity through access to quality services, "a skilled health workforce, and innovative programs."[174] In HRSA's guide for preparing grant applications, the agency outlines specific accessibility provisions and nondiscrimination requirements that grantees must comply with to help ensure accessibility by all individuals regardless of race, color, national origin, sex, age, and disability.[175] It also lists the contact information for HHS OCR and HRSA OCRDI for applicants and funding recipients who need assistance in understanding their civil rights obligations.[176]

Some HRSA programs also include nondiscrimination statements in their site agreements. The National Health Service Corps, a HRSA program that offers loan repayments and scholarships to healthcare providers in exchange for working in areas with limited access to quality healthcare, outlines certain requirements that must be met by site applicants at the time of application and throughout the award period. Specifically, the National Health Service Corps sites must,

> Provide services without regard to: a) the individual's inability to pay; . . . or c) the individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity.[177]

Additionally, it is important to note that in order to diversify its grant application review process, HRSA has publicly stated that it seeks "reviewers who have expertise in social, cultural, or health care issues of people in rural areas, migrants, or Native Americans."[178] HRSA has opened its grant reviewer applications to the public to help ensure a greater likelihood of retaining "experts from a wide variety of professions, work

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[173] *Early Hearing Detection and Intervention Program*, U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH RES. & SERVS. ADMIN., https://www.hrsa.gov/grants/find-funding/hrsa-20-047 (click on the "Notice of Funding Opportunity" hyperlink under the "Apply" subheading) (last visited Mar. 20, 2022).

[174] *Communicating and Acknowledging Federal Funding*, U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH RES. & SERVS. ADMIN., https://www.hrsa.gov/grants/manage/acknowledge-hrsa-funding (last visited Mar. 18, 2022).

[175] U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH RES. & SERVS. ADMIN., SF-242 APPLICATION GUIDE 3 (2022).

[176] *Id.* at 4.

[177] *How to Meet NHSC Site Eligibility Requirements*, NAT'L HEALTH SERV. CORPS, HEALTH RES. & SERVS. ADMIN., https://nhsc.hrsa.gov/sites/eligibility-requirements (last visited Mar. 20, 2022).

[178] *How to Become a Grant Reviewer*, U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH RES. & SERVS. ADMIN., https://www.hrsa.gov/grants/reviewers (last visited Mar. 18, 2022).

settings, and cultural backgrounds,"[179] and reflecting the diversity of the grantee pool and subjects of the proposed funded projects.[180]

3. Award Phase - Award Decisions and Notifications

Once a funding agency completes the application review process, the award phase begins. Grant reviewers make award recommendations based on programmatic and financial reviews of the applications. They also review an applicant organization's financial risk and its possible impact on program performance and federal funds. These recommendations are reviewed at multiple levels within the agency "to ensure high-quality, fair, and unbiased decisions."[181]

Once final award decisions are made, the funding agency issues a Notice of Award to the entity selected for funding. The Notice of Award is the official, legally binding issuance of the award. When an entity accepts the grant by signing the agreement or drawing down federal funds, they "become legally obligated to carry out the full terms and conditions of the grant."[182]

The Office of Management and Budget has developed draft language for federal agencies to use in the award terms and conditions in which funding recipients acknowledge that they must provide, for example, "meaningful access" to individuals who are LEP to comply with Title VI of the Civil Rights Act and the implementing regulation of the specific Department.[183] This written commitment serves multiple purposes: it provides recipients with the opportunity to become aware of and learn more about their civil rights obligations and allows both the funding agency and civil rights enforcement office the authority to rescind funding in response to noncompliance.

4. Post Award - Monitoring (Data Collection) and Closeout

The post award phase includes implementing the grant, monitoring progress, and completing the closeout requirements. Funding agencies monitor awardees' progress and expenditures through various programmatic and financial reporting procedures and using performance metrics per the grant agreement.

To help funding recipients promote compliance with federal civil rights laws, some funding agencies provide technical assistance and trainings on how to address and prevent potential risk factors related to the success of

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[179] Mary K. Wakefield, *Letter to Health Care Professional*, U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH RES. & SERVS. ADMIN., https://www.hrsa.gov/sites/default/files/hrsa/grants/reviewers/letter.pdf (last visited Mar. 18, 2022).

[180] U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 178.

[181] *Award Phase*, GRANTS.GOV, https://www.grants.gov/web/grants/learn-grants/grants-101/award-phase.html (last visited Mar. 10, 2022).

[182] *Id.*

[183] Rubin-Wills, *supra* note 151, at 490.

their grant.[184] Recipients may be hesitant to contact civil rights enforcement offices for questions regarding accessibility and compliance out of fear of initiating a review of their program. However, because many funding subcomponents within larger agencies do not have civil rights enforcement authority and are in direct contact with their recipients, recipients are more likely to approach those subcomponents directly with questions around providing nondiscriminatory services.

HRSA OCRDI provides tailored technical assistance and resources to its funding recipients upon request and assists in identifying solutions and strategies to promote accessibility in HRSA programs. OCRDI has provided training to its recipients on complex areas of the law, including recipients' language access obligations under Title VI of the Civil Rights Act and disability access under Section 504 of the Rehabilitation Act.[185] It has presented at recipient-focused conferences, such as the annual HRSA Healthy Grants Workshops (assisting recipients in managing their grants)[186] and the National Ryan White Conference on HIV Care and Treatment (providing training and technical assistance to Ryan White HIV/AIDS Program recipients).[187] OCRDI's consultations also inform its fact sheets, which are frequently uploaded and updated on its website.[188]

Additionally, through recipients in the post-award phase, funding agencies monitor both the health status of different population groups and programmatic impact to reduce inequities to inform ongoing federal interventions.[189] HRSA's Office of Health Equity publishes Health Equity Reports that specifically analyze HRSA's program efforts on "reducing health disparities and promoting health equity for various populations at the national, state, and local levels."[190] The Office of Health Equity develops its report in partnership with HRSA's Bureaus and Offices to examine improvements in health equity stratified by socioeconomic and demographic characteristics of populations that are underserved, such as gender, race, education, employment status, rural-urban residence, income, and other factors.[191] The 2019–2020 Report included a specific chapter on the impact of civil rights on health equity focusing in particular on affordable and safe housing.[192]

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[184] *Office of Civil Rights, Diversity & Inclusion*, *supra* note 122.

[185] *Healthy Grants Workshops*, U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH RES. & SERVS. ADMIN. (2022), https://www.hrsa.gov/grants/manage-your-grant/training/workshops.

[186] *Id.*

[187] *Virtual 2022 National Ryan White Conference on HIV Care & Treatment*, U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH RES. & SERVS. ADMIN., https://ryanwhiteconference.hrsa.gov/ (last visited Mar. 19, 2022).

[188] *Office of Civil Rights, Diversity & Inclusion*, *supra* note 122.

[189] Erik Blas et al., *Addressing Social Determinants of Health Inequities: What Can the State and Civil Society Do?*, 372 THE LANCET 1684 (2008).

[190] OFF. OF HEALTH EQUITY, *supra* note 17, at 117.

[191] *Id.* at 5.

[192] *Health Equity Report 2019-2020: Special Feature on Housing and Health Inequalities*, U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH RES. & SERVS. ADMIN. (2020), https://hrsa.gov/sites/default/files/hrsa/health-equity/HRSA-health-equity-repoty-printer.pdf.

Alongside civil rights enforcement, funding agencies must continue to engage in deeper research and empirical data collection in a civil rights context to understand gaps in access to federal programs by populations that are underserved and what interventions are needed to address them.[193] Each year, the HRSA Maternal and Child Health Bureau ("MCHB") is the primary sponsor and overseer of the National Survey of Children's Health, a national and state-level survey, which collects information on the health and health care needs of children zero to seventeen years old, including children with disabilities.[194] This information is used to inform federal and state-level policy and program development[195] and provide key measures to track improved health outcomes.[196] Funding agencies should expand their resource allocation to commission similar empirical research that tests the effectiveness of grants and recipient policies in reducing health disparities and discrimination.

5. Agency and Recipient Planning

As part of their various roles, funding agencies act as consultants to recipients on accessibility challenges and advise on how to prevent discrimination in their programs.[197] Funding recipients are encouraged by federal agencies, such as HRSA, to draft implementation plans that address the identified needs of populations that are underserved, such as people who are LEP or people with disabilities, and how recipients will respond to them.[198] Recipients have broad flexibility in developing implementation plans given factors such as, in the language access context, the number of LEP beneficiaries that are likely to be encountered by the recipient's program, the frequency with which LEP beneficiaries come into contact with the program, the nature and importance of the program, and the resources available to the recipient.[199] In most cases, however, recipients must provide some form of language assistance service to ensure their programs and activities are accessible to persons with LEP. A similar analysis may be used to plan on increasing program accessibility by other communities that are underserved, such as people with disabilities.

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[193] Rosenbaum & Schmucker, *supra* note 81.

[194] *Participants Frequently Asked Questions*, U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH RES. & SERVS. ADMIN. (2021), https://mchb.hrsa.gov/data/national-surveys/participants.

[195] *The National Survey of Children's Health*, DATA RES. CTR. FOR CHILD & ADOLESCENT HEALTH (2022), https://www.childhealthdata.org/learn-about-the-nsch/NSCH.

[196] *Children and Youth with Special Health Care Needs*, U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH RES. & SERVS. ADMIN. (2021), https://mchb.hrsa.gov/maternal-child-health-topics/children-and-youth-special-health-needs.

[197] Rubin-Wills, *supra* note 151, at 485–86.

[198] U.S. DEP'T OF HEALTH & HUM. SERVS., GUIDANCE TO FEDERAL FINANCIAL ASSISTANCE RECIPIENTS REGARDING TITLE VI PROHIBITION AGAINST NATIONAL ORIGIN DISCRIMINATION AFFECTING LIMITED ENGLISH PROFICIENT PERSONS 24 (July 26, 2019), https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-...ncy/guidance-federal-financial-assistance-recipients-title-vi/index.html.

[199] *Id.* at 4.

Although it is not a legal requirement for funding recipients to draft and implement language access or disability access plans, both federal agencies and their recipients are obliged to ensure accessibility by populations that are underserved, such as people who are LEP or with disabilities, to federally administered and funded programs and activities.[200] All HHS agencies, including HRSA, have developed accessibility plans that provide a framework for ensuring meaningful access to populations that are underserved.[201] Additionally, some HHS funding agencies, such as the Centers for Medicare & Medicaid Services and the NIH, have developed resources to assist recipients in creating language access plans that ensure high-quality language assistance.[202] Similarly, HRSA has developed a Language Access Worksheet, Disability Access Worksheet, and related resources to assist recipients in conducting needs assessments of populations that they serve and how to, based on that assessment, develop written accessibility plans.[203]

The creation, maintenance, and wide distribution of a periodically updated accessibility plan is a cost-effective means of promoting compliance with federal civil rights laws and the timely provision of language assistance or reasonable accommodations.[204] These plans may provide additional benefits to funding recipients in areas such as training, administering, planning, and budgeting for accessibility services.[205] For example, a language access plan may include organizing translated resources and documents in a central location for staff to easily determine what translated resources are available and current. This would increase data consistency, limit redundant translation costs, and reduce reliance on outdated materials.

Appropriate planning also allows funding recipients to include costs in their grant budget application, which in turn would allow them to utilize federal funds for accessibility related costs, such as interpreters. By adopting systematic policies, procedures, and staff trainings on promoting accessibility, recipients' programs and operations run more effectively and efficiently.[206] For example, if an entity purchases an accessible exam table or implements a contract to provide language assistance services but does

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[200] 45 C.F.R. § 85.61(d) (2022); Executive Order 13,166: Improving Access to Services for Persons with Limited English Proficiency, 65 Fed. Reg. 50, 121 (Aug. 16, 2000).

[201] U.S. DEP'T OF HEALTH & HUM. SERVS., LANGUAGE ACCESS PLAN 3 (2013).

[202] *Guide to Developing a Language Access Plan*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2022), https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan-508.pdf; *Language Access in Clear Communication*, NAT'L INSTS. HEALTH (2021), https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liason/clear-communication/language-access-clear-commnication.

[203] *Language Access Plan Worksheet*, U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH RES. & SERVS. ADMIN., https://www.hrsa.gov/sites/default/files/hrsa/grants/manage/technicalassistance/language-access-plan-worksheet.pdf (last visited Mar. 26, 2022).

[204] U.S. DEP'T OF HEALTH & HUM. SERVS., *supra* note 198, at 3.

[205] *Id.*

[206] Rubin-Wills, *supra* note 151, at 502.

not develop policies and trainings for how to utilize these resources, that entity runs the risk of wasting resources.

One of the most significant benefits to funding recipients in creating accessibility plans is ensuring compliance with relevant federal civil rights laws. Conversely, recipients are at risk of non-compliance with federal civil rights laws, civil liabilities related to injury or other harms resulting from discriminatory conduct (e.g., medical malpractice claims), and adverse enforcement actions without proper accessibility plans and nondiscrimination protocols. Additionally, the benefits of planning effectively extend to recipient operations. For example, when recipients cannot communicate effectively with LEP individuals, they can end up with longer lines, wasted staff time, duplicated efforts, and costly delays. By adopting systematic language access policies and training staff on how to implement them, recipients can run their operations more effectively and efficiently by serving all populations.[207]

6. Accessibility Reviews of Funded Programs

Federal civil rights enforcement offices are directed to periodically initiate compliance reviews[208] of entities to review their policies, procedures, and practices, and address "comprehensive, systemic issues."[209] While enforcement offices have the authority to use compliance reviews as an enforcement tool to gather information for determining whether an entity is violating federal civil rights laws,[210] they may achieve broader recipient compliance by providing technical assistance, consultations, and education. Additionally, as indicated earlier, recipients may be more candid with staff employed by a funding agency, as opposed to civil rights investigators, in asking questions about promoting accessibility and implementing mechanisms to ensure meaningful access by populations that are underserved.

Federal funding agencies may consider integrating accessibility and civil rights related protocols into recipient site visits. For example, HRSA's Bureau of Primary Health Care provides funding to health centers, which are community-based and patient-directed organizations that deliver comprehensive, culturally competent, and high-quality healthcare services.[211] Notably, health centers provide services regardless of patients' ability to pay and charge for services on a sliding fee scale. Some health centers receive funding to focus on special populations, such as individuals

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[207] *Id.*; OFF. OF MGMT. & BUDGET, ASSESSMENT TOTAL BENEFITS & COSTS IMPLEMENTING E.O. 13,166: IMPROVING ACCESS TO SERVICES FOR PERSONS WITH LIMITED ENGLISH PROFICIENCY (Mar. 14, 2002).

[208] 45 C.F.R. § 80.7 (2022); Section 504 of the Rehabilitation Act (45 C.F.R § 84 app. A).

[209] U.S. COMM'N ON C.R., ARE RIGHTS A REALITY?: EVALUATING FEDERAL AND CIVIL RIGHTS ENFORCEMENT 228 (2019).

[210] *Id.*

[211] *What is a Health Center?*, U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH RES. & SERVS. ADMIN., https://bphc.hrsa.gov/about/what-is-a-health-center/index.html (last visited Mar. 19, 2022).

experiencing homelessness, migratory and seasonal agricultural workers, and residents of public housing.[212] The Bureau of Primary Health Care conducts regular operational site visits to objectively assess and verify the status of each Health Center Program awardee's compliance with HRSA's program requirements. As an additional layer of assistance with compliance, federal funding agencies may consider developing and incorporating materials that address accessibility by people who are LEP or with disabilities, as well as resources for recipients to address potential gaps in access to care.

Federal funding agencies can also partner with civil rights enforcement offices to conduct compliance reviews. Funding agencies can bridge gaps in programmatic knowledge between enforcement offices and recipients. They can also provide targeted trainings and technical assistance, alongside enforcement offices, to recipients with specific needs or population demographics. By assisting funding recipients in updating policies and procedures to prevent discrimination, compliance reviews (or an added accessibility component to site visits) would lead to more efficient, effective, and accessible federally funded programs and services.

7. Resource Development and Coordination

In addition to funding recipients' federal civil rights law compliance obligations, civil rights advocates continue to push federal agencies to tailor their regulations and guidance more clearly and specifically to recipients to prevent discrimination and reduce reliance on enforcement. The majority of federal civil rights regulations were written several decades ago and contain little instruction on how recipients can implement their programs in a manner compliant with the law.

Federal guidance provides examples of best practices and a useful analytical framework that can help funding recipients determine how best to comply with statutory and regulatory obligations given their individual resources and the populations they serve. To further clarify the nondiscrimination mandate in the Title VI regulation,[213] President Clinton issued Executive Order 13,166, which directed each federal agency to "develop and implement a system by which LEP persons can meaningfully access" programs and services; this included creating guidance for funding recipients.[214] Shortly thereafter, HHS established the Departmental Language Access Steering Committee, which is responsible for supporting the development and implementation of HHS language access initiatives and collaborations across the Department, and evaluating HHS's progress in

[212] *Id.*

[213] 45 C.F.R § 80.3(b)(2) (stating that a recipient cannot "utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals of a particular race, color, or national origin").

[214] Executive Order 13,166: Improving Access to Services for Persons with Limited English Proficiency, 65 Fed. Reg. 50,121 (Aug. 16, 2000).

meeting its obligations under Executive Order 13,166.[215] The HHS Departmental Language Access Steering Committee is led by the Director of HHS OCR and is comprised of representatives from every HHS operational and staff division, including HRSA.[216] Additionally, to further the directives in Executive Order 13,166, HHS published its Title VI guidance covering: (1) the four-factor analysis to help recipients determine how best to provide meaningful access; (2) standards for oral interpretation and written translation; (3) elements of an effective language access plan; and other assistance still referenced over two decades after its publication.

Unfortunately, with various competing legal obligations placed upon recipients, it can be difficult for funded entities to parse through hefty policy documents that sometimes contain legal terms unknown to the average educated reader (e.g., "disparate impact," "effective communication," etc.). HRSA has created a frequently updated library of technical assistance materials written to assist HRSA recipients in understanding their civil rights obligations.[217] Topics include how to create disability and language access plans, service animals, video remote interpreting, and other areas that are frequently unknown or misunderstood by recipients. These fact sheets are intentionally written in plain language, under five pages long, and provide "bite-sized" information about potential strategies that recipients can utilize to comply with the law.

HRSA also consults with funding recipients that are seeking help in allocating limited budget funds towards services that help increase access by populations that are underserved. HRSA assists recipients in strategizing how to meet the needs of their service populations in a cost-effective manner.[218] For instance, HRSA encourages recipients, as appropriate, to seek out organizations in their localities or with similar missions to negotiate resource sharing agreements. Such arrangements take shape in a variety of ways, such as cost sharing on a contract for interpreter services to communicate with patients with disabilities or who are LEP or sharing translated informational materials. Cost sharing may result in lower rates from increased volume or dividing the cost of one service among multiple organizations.

Similarly, as a means of accessing a wide range of information without incurring additional cost, HRSA encourages funding recipients to utilize connections within their communities. Recipients can utilize expertise from local organizations, such as HHS/ACL-funded Centers for Independent Living on disability issues or coordinate with religious entities to disseminate materials and reach all segments of the community. It is important to note that when utilizing these strategies, HRSA strongly

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[215] U.S. DEP'T OF HEALTH & HUM. SERVS., LANGUAGE ACCESS PLAN 3 (2013), https://www.hhs.gov/sites/default/files/open/pres-actions/2013-hhs-language-access-plan.pdf.

[216] *Id.* at 4.

[217] *Office of Civil Rights, Diversity, & Inclusion*, *supra* note 122.

[218] *Healthy Grants Workshops*, U.S. DEP'T OF HEALTH & HUM. SERVS., HEALTH RES. & SERVS. ADMIN. (2020), https://www.hrsa.gov/grants/manage-your-grant/training/workshops.

promotes implementing quality assurance mechanisms, such as including a statement on borrowed translated materials that requests feedback from consumers to help the entity ensure that the documents are accurate and effective.

To reduce modern health inequities, it is not enough for funding agencies to simply request that entities sign grant agreements; funding agencies should also continue to assist recipients in the post-award phase in understanding legal directives and federal civil rights guidance to help them achieve compliance, dismantle health disparities among the populations they serve, and reduce discrimination in funded programs and activities.

CONCLUSION

Systemic discrimination and widespread health disparities demand federal action in addition to enforcement. Federal funding agencies—through grants, technical assistance, outreach, and partnerships with civil rights enforcement offices—can help achieve equity across publicly funded programs and services. Through civil rights laws, federal funding influences policies that affect SDOH such as healthcare, education, climate, transportation, and other critical areas that impact health. Funding agencies provide a strategic complement to civil rights enforcement by not only affirming nondiscrimination in federally funded programs, but also educating funding recipients on how to devise, adapt, or extend programs and services in ways that *prevent* discrimination, increase access to healthcare, and promote health equity.

HRSA is in a unique position to help its funding recipients proactively integrate civil rights compliance in its policies, programs, and services. Interweaving civil rights requirements into grant administrative requirements supports applicants and recipients in understanding what is expected of them. HRSA takes this one step further by inviting its recipients to ask questions or request consultations on civil rights implementation in funded programs. Modern forms of discrimination and health inequities require federal departments, such as HHS, to extend nondiscrimination efforts beyond investigations of individual cases and towards guiding recipients, using funding mechanisms, on how to apply civil rights standards in their programs. The reach of civil rights laws through proactive efforts by federal funding agencies is significant, transformative, and necessary to further health equity.