

Disability Rights and Managed Care Fact Sheet

October 2014

Introduction

For many who work in the healthcare arena, “access to healthcare” is primarily a matter of health insurance coverage, and “healthcare accessibility” is an unfamiliar term. For many people with disabilities, access to healthcare is not only about a lack of coverage, but includes many other barriers that prevent them from gaining access to equal and effective healthcare. People with a wide range of disabilities that affect mobility, vision, hearing, communication, cognition, reasoning, judgment and other functional capacities find the average provider’s office and the healthcare system to be inaccessible. This is so despite the decades-long existence of disability rights in federal and state laws. Under these laws, healthcare providers and entities are required to modify physical conditions and policies so that people with disabilities can receive equally effective services. This Fact Sheet provides a basic introduction to the origins of disability rights, who they apply to, and what those rights practically mean in a healthcare context.

Sources of Disability Rights

Currently there are five main sources of disability rights law and guidance

- Federal Law and Regulations

The Americans with Disabilities Act of 1990 (ADA) is probably the most well-known of the federal disability rights laws. However, Section 504 of the Rehabilitation Act of 1973 is the older federal law on which the ADA was modeled. Section 504 is particularly important in healthcare because it governs entities that receive federal funds and assistance, as well as programs and activities that are conducted by the federal government itself. Given the reach of federal Medicaid and Medicare funds, Section 504’s requirement that people with disabilities have full and equal access to healthcare services binds much of the American healthcare industry. A more recent law, Section 508 of the Rehabilitation Act, requires accessibility in information and online technology systems that are federally conducted. Most recently, the Affordable Care Act (ACA) explicitly incorporates Section 504 with regard to “any health program or activity, any part of which is receiving federal financial assistance, including credits, subsidies or contracts of insurance, or under any program or activity that is administered by an Executive [federal] Agency,” so its non-discrimination requirements clearly apply to Medicaid expansion and Marketplace activities.

- State Law and Regulations

Every state has enacted laws that generally cover the rights of people with disabilities to physical access to, and use of goods and services offered by, both government and private business entities, and that prohibit discrimination based on disability. These laws can vary considerably from state to state in such aspects as how the right is to be enforced (e.g., can a person file a complaint with a state agency, file a lawsuit, and/or get monetary damages if a violation is found?), the precise accessibility standards that must be met, any exemptions to the law's application, and whether/how compliance is monitored. The most important thing is to know that these laws exist, and that they apply both to managed care companies that are headquartered in a particular state, and to managed care activities in a particular state(s).

- Medicare and Medicaid Laws and Regulations

Both the Medicare and Medicaid programs have specific disability non-discrimination provisions that apply to program participants. For example, Medicaid regulations require managed care contracts to prohibit discrimination on the basis of health status or requirements for health services in enrollment, disenrollment, and re-enrollment. A state's Medicaid program cannot discriminate on the basis of medical condition in providing its mandatory Medicaid services. Medicare regulations prohibit Medicare plans from discriminating on the basis of mental or physical disability, health status, claims experience, medical history, genetic information, and evidence of insurability, among other bases. In addition, basic services and information must be made available to individuals with disabilities upon request.

- Court Cases Interpreting Laws and Regulations

Federal and state courts can definitively interpret the laws that are in their respective jurisdictions. The most critical court interpretations are those made by the highest level courts since lower court decisions can be appealed and overturned within certain time frames. Specific to healthcare, the U.S. Supreme Court has issued at least two very significant disability rights decisions. In *Bragdon v. Abbot* (1998), the Supreme Court found a violation of the ADA when a dentist refused to treat a patient who had HIV. In *Olmstead v. L.C.* (1999), the Supreme Court found a state in violation in the ADA for failing to provide needed supports and services in the community, instead of in segregated institutions. In the *Olmstead* decision, the plaintiffs had developmental disabilities and/or mental illness and were housed in a state psychiatric hospital, despite their desire to return to and live in the community. Staff medical opinion also supported their ability to do so. These decisions have helped shape how people with disabilities, disability advocates, and state agencies understand the requirements of disability rights law.

- Federal and State Guidance on Specific Access Issues

Federal agencies who are given responsibility and authority to enforce disability rights laws will often issue less formal guidance on what the laws require, in addition to actual regulations. While federal agency guidance does not have the force of law in itself, they often take the form of practical documents that provide excellent tips and best practices for complying with the law. One such example is the *Access to Medical Care for Individuals with Mobility Disabilities*¹ brochure that was jointly issued by the federal Departments of Justice and the Health and Human Services' (HHS) Office of Civil Rights in July 2010. In another example, in May 2013 the Centers for Medicare and Medicaid Services issued *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs*. CMS references both the Americans with Disabilities Act (ADA) and the Supreme Court's *Olmstead v. L.C.* decision when they state that "[Managed Long Term Services and Supports (MLTSS)] must be delivered in the most integrated fashion, in the most integrated setting, and in a way that offers the greatest opportunities for active community and workforce participation."² In August 2014, HHS provided a recent example of a federal agency recognizing its own obligations under federal disability access laws by issuing the *Commitment to Action to Resolve DREDF Section 504 Complaints*,³ under which CMS outlines steps that it will take to ensure effective communication with beneficiaries in CMS programs.

Scope of Application

- The ADA and Section 504 apply broadly to federal, state, and municipal government entities across such major areas as telecommunications, civic services, transportation, and healthcare services. The ADA applies to the gamut of privately owned businesses and services, explicitly including the "professional office of a health care provider, hospital, or other place of other service establishment."
- Federal disability rights law defines an individual with a disability. The definition is distinct from how "disability" is defined under Social Security laws, state welfare programs, or any meaning common to health insurance, Medicaid or Medicare purposes. For disability rights purposes, someone falls under the protection of the law if they have a physical or mental impairment that substantially limits one or more major life activities; a record (or past history) of such an impairment; or are regarded as having a disability. Federal law makes it clear that the definition does not require extensive analysis and is to be broadly interpreted. The focus should be on what a covered entity or provider should do

¹ Available at: http://www.ada.gov/medcare_mobility_ta/medcare_ta.htm

² Available at: <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf>

³ Available at: <http://www.hhs.gov/ocr/civilrights/activities/agreements/cms.html>

to comply with the law, and not on applying scientific, medical or statistical standards to the functions that a person can or cannot perform.

- The laws recognize the right of people with disabilities to be free of discrimination in all facets of life. For the purposes of managed care, the obligation to ensure physical accessibility, to provide effective communication, and to modify policies and procedures as needed would apply to such health-related services as providing healthcare and health plan information, applying to and maintaining participation in state and federal benefits programs, examinations and diagnostic tests, participation in such plan-related services as healthcare assessments and care coordination, and equal participation in any other services offered in conjunction with managed care, including mental health, vision, dental, long-term services and supports benefits, and enrollment and advocacy assistance.

What Do Disability Rights Require?

The obligations of healthcare providers and entities fall generally into three categories:

- Full and equal **physical access** to health care services and facilities;
- **Effective communication** for both service delivery and program participation, including auxiliary aids and services, such as the provision of Sign Language interpreters or written materials in alternative formats; and
- **Reasonable modifications** to policies, practices, and procedures when necessary to make health care services accessible;

Physical Access – Structures and Facilities

For any space that is open to the public (or to “members,” if the public is generally eligible to become a member), the law requires accessible paths of travel, elevators, ramps, doors that open easily, reachable light switches, accessible bathrooms, waiting areas and exam rooms that allow a wheelchair or scooter to maneuver, accessible parking, and signage that can be used by individuals who are blind or have low vision.⁴

Physical Access – Services

Health care providers and entities must provide accessible equipment such as height-adjustable exam tables and diagnostic equipment that does not depend on patients independently standing or holding a certain position, and use a lift or trained staff as

⁴ The degree to which an entity must make its premises structurally accessible can vary depending on factors such as the age of a building, whether the entity receives federal or state funds, and whether the entity has fewer than 15 employees. More information about physical access requirements is available at: 28 C.F.R. § 35.151 (Title II); 28 C.F.R. Part 36, Subpart D (Title III). Regulations available at: <http://www.ada.gov/reg2.html> and <http://www.ada.gov/reg3a.html>. See also, <http://www.ada.gov/racheck.pdf>

needed, to ensure medical examinations and tests that are as effective for people with various disabilities as for people without disabilities.⁵ Office staff must also appropriately schedule the use of accessible rooms, equipment, and trained staff to ensure availability as needed.

Effective Communication

Under the ADA, healthcare providers and entities must provide effective communication for patients, family members, and visitors who are blind or visually impaired or Deaf or hard of hearing. The method that the health care provider can use for effective communication will vary depending on the abilities of the individual, his or her preferences for communication, and the complexity, importance, and nature of the communications required. A person who is Deaf may be comfortable exchanging short notes when they want to buy a sweater, but may not be comfortable enough with written English to use notes to discuss a diagnosis or health condition. Similarly, someone who is blind or visually impaired cannot be expected to memorize information upon a single hearing, but may need self-care instructions and prescription information in an alternative format such as large font, a CD, or Braille so that they can refer back to detailed information over time.

Health care providers and entities must give priority to the method of communication requested by the person with a disability. Possible auxiliary aids and services for individuals who are blind or visually impaired include readers, taped texts, Braille materials, assistance with filling out forms, modifying equipment such as computer kiosks that the public uses to sign in or find a patient room, or providing other effective means of conveying and exchanging information. Auxiliary aids and services for individuals who are deaf or hard of hearing are equipment or services such as qualified Sign-Language interpreters, assistive listening devices, note takers, written materials, television decoders, closed caption decoders, and real-time captioning.⁶

Whatever method of communication is used, individual privacy and independence must be respected. Healthcare providers and entities cannot require individuals to bring a third party with him or her to interpret or facilitate communication, and outside of specified emergency circumstances, also cannot rely on a companion or family member who is accompanying the individual. Qualified sign-language interpreters, and voice and video relay operators are usually already required to adhere to ethical and professional confidentiality standards. Finally, a health care provider cannot impose a special charge for providing interpretation services or alternative formats.

Reasonable Modifications

The ADA and Section 504 provides protection from discrimination for people with all types of disabilities, including physical, cognitive, communication, and mental health

⁵ http://www.ada.gov/medcare_mobility_ta/medcare_ta.htm#accessmedequip

⁶ More information is available at <http://www.afb.org/info/programs-and-services/public-policy-center/ada-checklist-health-care-facilities-and-service-providers/125>; <http://www.ada.gov/hospcombr.htm>.

disabilities. Health care providers and entities must make “reasonable modifications in policies, practices and procedures” when necessary to ensure that people with disabilities receive an equally effective healthcare service. Providers and covered do not have to make modifications that would “fundamentally alter the nature of the service, program or activity,” but this is a high and rarely met standard. An individual provider would not have to make a specific modification if the result would somehow prevent her from practicing, but not recouping full interpreter costs for a single patient would not have this result.

Here are some examples of the kinds of changes that healthcare providers and entities may have to make to accommodate people with disabilities:

- Providing, or reimbursing, the extra time needed to explain a procedure to a patient who has a cognitive disability and might have difficulty understanding;
- Scheduling an appointment at a specific time to accommodate a patient with an anxiety disorder who has difficulty waiting in a crowded waiting room;
- Providing an appointment window to someone who relies on paratransit or other accessible public transportation services that only pick-up and drop off within a multi-hour time range;
- Modifying standard rehabilitation program admission requirements or procedures for patients with chronic conditions and treatment regimens;
- Allowing patients to be accompanied by service dogs.

How to Provide Accommodations

Health care providers must ensure that individuals are informed of their right to request accommodations and modification; provide individuals with information about the process for requesting accommodations/modifications; and provide individuals with information about how to file complaints if a provider is inaccessible (e.g., to a managed care organization, a state Medicaid agency, or to federal departments that oversee the administration of disability rights in the healthcare context).⁷

⁷ See, e.g., U.S. Department of Health and Human Services Office of Civil Rights (OCR) www.hhs.gov/ocr/civilrights/complaints; United States Department of Justice (DOJ), www.askDOJ@usdoj.gov.

Important Final Points

- An individual provider or entity's failure to provide reasonable accommodations or modifications, or otherwise ensure accessibility, can be a violation of disability rights law regardless of whether there was any ill will or "intentional" desire to discriminate against a patient.
- U.S. healthcare providers and entities are obligated to comply with general disability rights and accessibility laws because they are part of the laws of this country, even if those laws are not explicitly referenced in Medicaid, Medicare, or health insurance contracts. In fact, federal or state contracts usually do include reference to the contractor's general obligation to comply with nondiscrimination laws. The extent of the obligation may not be spelled out, but the absence of contractual detail does not change the scope and extent of the laws and regulations that apply.
- Direct communication with people with disabilities is often the best way to determine how to meet their needs. Someone who has had a disability or functional impairment for many years will usually know the healthcare accommodation, modification or assistance that they need. At the same time, providers and entities cannot rely solely on the knowledge of individual patients, especially seniors and others who have acquired a disability relatively recently. Some people with disabilities will not know about disability rights or the range of accommodations/modifications that are available. The best practice for providers and entities is to notify the public about disability rights and provide accommodations/modifications as necessary to ensure that people with disabilities receive an equally effective healthcare experience and service