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ADA Obligations Of Health Providers Are Magnified By ACA

Law360, New York (February 27, 2014, 6:03 PM ET) -- America's heated health care policy debates have taken place against the backdrop of significant enforcement and regulatory activity under the Americans with Disabilities Act, the Rehabilitation Act of 1973 and other disability statutes. Much of this recent activity has been targeted at health care providers, which fall within the definition of "public accommodations" under Titles II and III of the ADA, affecting public and private entities respectively. Like all other public accommodations, health care providers are charged under the ADA with the legal obligation to make their goods, services, accommodations and facilities accessible to individuals with disabilities; make reasonable policy modifications; and remove barriers so that accessibility is afforded to the maximum extent reasonably feasible.

Disability Statutes and the Affordable Care Act

For the last two years, the U.S. Department of Justice has devoted considerable attention to the issue of accessibility to health care for individuals with disabilities. The DOJ's "Barrier-Free Health Care Initiative," in which U.S. Attorneys' offices across the nation partner with the DOJ's Civil Rights Division to prosecute health care providers deemed to be noncompliant with the ADA and the Rehab Act, has resulted in significant claims against health care providers.

The DOJ has secured dozens of settlement agreements and consent decrees with health care providers, many focused on the issue of effective communication with blind and hearing-impaired individuals through the use of appropriate auxiliary aids, as well as various other issues, including physical barriers and policies.

This enforcement initiative has unfolded amid ADA regulatory activity directed at the health care industry. In September 2010, the DOJ amended its ADA regulations and issued updated standards for accessible design of facilities, including health care facilities. The revised standards, which became effective on March 15, 2012, included many additional technical requirements for medical care facilities.

Most recently, an advisory committee created by the U.S. Access Board issued a report with detailed recommendations for technical standards for accessible medical diagnostic equipment ("MDE"), including new standards for the appropriate dimensions of transfer surfaces on MDE, lift compatibility and features affecting wheelchair users, such as the orientation, depth, width, knee and toe clearance and surface slope required to provide effective wheelchair access to different pieces of equipment. These standards would require significant redesign of often expensive MDE.

The sprawling body of rules and regulations created by the Affordable Care Act overlaps in many ways with the ADA's regulatory scheme, resulting in heightened scrutiny of ADA compliance by health care

providers. For instance, the MDE advisory committee's work mentioned above is the direct result of Section 4203 of the ACA, which amended a section of the Rehab Act to require the U.S. Access Board, in consultation with the U.S. Food and Drug Administration, to issue accessibility standards for MDE.

Medicare-Medicaid "Dual Eligible" Test Programs and the ADA

Indirect connections between the ACA and the ADA also lead to greater scrutiny of ADA compliance by health care providers. One such example is a test program designed to enhance efficiencies in the delivery of care to persons who are eligible for both Medicare and Medicaid (so-called "dual eligibles"), administered by the Medicare-Medicaid Coordination Office ("MMCO") of the Centers for Medicare & Medicaid Services.

That office was created by Section 2602 of the ACA for the purpose of better coordinating the care of the dual-eligible population, a group with complex health care conditions who tend to experience difficulty navigating these programs to obtain available benefits. In an effort to integrate health services and support for dual eligibles, CMS has implemented a test program in which it seeks to align the financial incentives of Medicare and Medicaid.

CMS will select 15 states and partner with them to test one of two models for providing high-quality, cost-efficient care to the dual-eligible population. In the "capitated model," a state, the CMS and a Medicare-Medicaid health plan ("MMP") will enter into a three-way contract and the plan will receive a prospective blended payment to provide comprehensive, coordinated care.

In the "managed fee-for-service model," a state and the CMS will enter into an agreement by which the state would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid. Under either approach, the CMS will provide funding and technical assistance.

There is strong interest in this test program, not least because cash-strapped state governments seek to contain health care costs. More than half the states have submitted proposals, and, to date, eight of them — California, Illinois, Massachusetts, New York, South Carolina, Ohio, Virginia and Washington — have been admitted into the program and signed a memoranda of understanding with CMS to test a capitated model.

To be considered for participation in this initiative, states must submit proposals outlining their approach to "person-centered," coordinated care for the dual-eligible population, to include primary and acute care services, behavioral health care services, and long-term supports and services. The proposals are evaluated against standards and conditions established by CMS, one of which is a commitment to comply fully with the ADA.

The memoranda of understanding recite, in similar language, the expectation that plans and providers will comply with the ADA, acknowledging that "person-centered care" requires physical access to buildings, services and equipment; flexibility in scheduling and processes; and communication with enrollees that accommodates the need for auxiliary aids or other supports.

ADA Implications of Readiness Reviews for "Dual Eligible" Test Programs

A key step in implementing the capitated model is a comprehensive readiness review of every selected MMP, conducted jointly by the CMS and relevant state, which examines (among other things)

assessment processes, care coordination and provider network development as well as staffing and training.

Verification of ADA compliance by network providers is one of the critical components of the readiness review and has captured the attention of advocacy and public policy organizations that represent the interests of individuals with disabilities. Such groups have publicly called for more stringent readiness review criteria for the provision of services to individuals with disabilities. The readiness review process includes issuing and reviewing compliance surveys to a sample of an MMP's network providers and conducting on-site visits of selected provider facilities to verify ADA compliance.

State-specific readiness review tools, developed jointly by the CMS and departments of health across the states, set forth detailed standards for ADA compliance. For example, Massachusetts requires evidence that provider service staffs are knowledgeable about effective communication to and from individuals with disabilities, including through the use of tools such as TTY, computer-aided transcription services, qualified interpreters for deaf individuals, telephone headset amplifiers, videotext displays, assistive listening systems and closed caption decoders. Evidence of this competency includes samples of service staff resumes showing experience in these areas, sample training modules for services staff and written materials informing enrollees of their right to reasonable accommodation.

California's readiness review tool requires the MMP to demonstrate that it conducts "disability literacy training" for its medical, behavioral and long-term social services providers, and that it has a dedicated website or webpage for this product that links to, among other things, materials furnished in alternative formats, such as large print, Braille and audio CD. California's emphasis on website accessibility is consistent with enhanced interest in this topic nationwide.

The DOJ has promulgated an advance notice of proposed rulemaking ("ANPR") to establish requirements for making goods and services offered via the Internet accessible to individuals with disabilities. The ANPR makes specific mention of the growing use of the Internet to obtain health care information, noting that "the inability of individuals with disabilities to … access this information can potentially have a significant adverse effect on their health." This issue increasingly is raised in litigation by advocacy groups for the disabled.

Readiness review surveys may be very detailed, and should not be taken lightly by health care providers. New York requires every provider to complete "attestation forms" for each of their facilities. This form consists of a series of yes-or-no questions about specific accessibility standards that are not tailored to the type of provider, services offered, age or ownership of a facility, or other highly relevant factors. The questions address standards for wheelchair accessibility, MDE, parking and numerous other accessibility standards, as defined by the Access Board and adopted by the DOJ.

Additional questions address the dimensions of lavatories in public restrooms, the slope of ramps, the width and surfaces of paths of travel, door clearance and hardware as well as the requisite number of accessible and van-accessible parking spaces. It is unlikely that most facilities can represent that they are fully compliant with all of the extremely detailed ADA accessibility standards, and many older facilities — often constructed prior to enactment of the ADA — may have more difficult compliance issues.

Those facilities constructed pre-ADA must meet the law's "readily achievable" standard, which is based on a fact-specific inquiry not recognized in the attestation form. Moreover, a provider may use auxiliary aids and/or equivalent facilitation to ensure services are provided to individuals with disabilities.

When relevant, such additional facts can and should be explained and placed into context when completing certification or "attestation" forms, to prevent erroneous conclusions as to an entity's ability to serve patients with disabilities. Carefully crafted explanations may require assistance from legal counsel familiar with ADA requirements and accessibility criteria adopted by the DOJ, especially as to the health care setting.

Ongoing ADA Compliance

The effect of having facilities that are substantially noncompliant with the ADA has yet to be determined, because the dual-eligible test programs are still in the early stages of implementation with enrollees only scheduled to receive services as of Jan. 1, 2015.

The CMS' long-term reporting requirements for capitated model programs do not presently include ADA compliance, rather, they focus on issues that pertain directly to patient care, such as serious reportable adverse events, grievances, enrollment and disenrollment, medication therapy management and long-term care utilization, and the reporting of fraud, waste, and abuse.

Nonetheless, given the stated importance of ADA compliance at all stages of this initiative, it appears possible that an attempt eventually could be made to exclude noncompliant facilities with the ADA from the network of providers permitted to serve dual-eligible patients. Of more immediate concern is the fact that attestations of noncompliance with the ADA could be fodder for litigious plaintiffs and advocacy organizations, arguing that they are admissions against interest in cases under Title II or Title III of the ADA. And, as noted, the Barrier-Free Health Care Initiative remains a DOJ priority.

The country's health care system is evolving, in large part in response to public policies underlying the ACA. Those policies frequently dovetail with those underlying the ADA and other disability statutes. Broad-based, affordable health care — particularly for the portion of the population that previously was not able to obtain health insurance — depends on unimpeded access to the health care system.

The CMS has retained contractors to evaluate the dual-eligible demonstration programs after their implementation, and it seems inevitable that health care plans and providers, in general, will be subject to ongoing, heightened scrutiny of their compliance with the ADA and the Rehab Act. Prudent providers will want to address ADA issues proactively, rather than in response to a government claim of noncompliance or the assertions of private litigants.

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