Q & A
Medicaid Managed Care and Disability Discrimination Protections

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Q. Are managed care plans that participate in the Medicaid program required to comply with Title II & III of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act?

A. Yes. Because they receive federal funds in the form of Medicaid payments, these managed care plans must comply with Section 504. Managed care plans are not public entities and are therefore not directly bound by Title II of the ADA. But, states are required to ensure that all public services comply with the ADA and Section 504, even if they are provided by private contractors. To this end, most managed care contracts require plans to comply with the ADA and other civil rights laws. Title III governs public accommodations, which include most managed care plans.

Discussion

Medicaid Managed Care

In 2010, more than 70% of Medicaid beneficiaries received services through some type of managed care arrangement.[2] Increasing numbers of people with disabilities, including those eligible for both Medicare and Medicaid (dual eligibles) are being required to enroll in mandatory managed care. Thus, advocates and policy makers are concerned about whether these populations will have access to the services and providers that they need.

States may require most Medicaid beneficiaries to enroll in managed care through by amending their state Medicaid plans.[3] The exceptions are: (1) individuals

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[2] CMS, Medicaid Managed Care Enrollment, July 1 2010, https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/2010July1.pdf.
[3] 42 U.S.C. § 1396u-2.

eligible for both Medicare and Medicaid (dual eligible), (2) children under age 19 with special needs, and (3) most Native Americans.[4] If a state wants to require these populations to enroll, they may apply for a waiver through 42 U.S.C. § 1396n(b), which allow them to waive many Medicaid requirements. They may also require them to enroll through 42 U.S.C. § 1315 (also known as section 1115) by proposing demonstration programs to test alternative service delivery methods.

There are three models of Medicaid managed care. First, **Managed Care Organizations (MCOs)** provide a package of services in exchange for a capitated payment for each enrollee. Managed care plans may enter into comprehensive risk contracts, through which they agree to provide certain services and incur a loss if the cost of providing services exceeds the capitated payment. They must offer at least three of the following services: outpatient, Federally Qualified Health Center (FQHC), nursing facility, Early and Periodic Screening, Diagnostic, and Treatment (ESPDT), family planning, home health, lab and x-ray, and physician services.[5] **Prepaid Inpatient and Ambulatory Plans (PHPs),** like MCOs, receive capitated payments, but offer a comprehensive package of services and do not have comprehensive risk contracts.[6] Finally, **Primary Care Case Managers (PCCMs)** are entities in which a primary care provider is paid a nominal, monthly per person fee to coordinate care for beneficiaries and receives fee-for-service reimbursement for services provided. [7]

Advocates and policymakers want to ensure that mandatory enrollment in managed care does not reduce Medicaid enrollees' access to covered services. This is a particular concern when individuals with disabilities are required to enroll in MCOs, because of the MCO's risk contrasts with state Medicaid agencies. It is costly to serve this population. In 2009, 43% of Medicaid expenditures were made for individuals under age 65 with disabilities, despite the fact that these enrollees comprise only 15% of the total Medicaid enrollment.[8] Because MCO contracts require them to incur loss if they spend more on services than they receive through their contracts, there is a strong incentive to deny coverage of services to keep costs down.

There are a number of safeguards in the Medicaid Act and regulations intended to ensure that enrollees obtain necessary services and quality care. For example, MCOs and PHPs must ensure that services are accessible to the same extent as to recipients not enrolled in the plan.[9] Contracts must also prohibit discrimination on the

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[4] 42 U.S.C. § 1396u-2(a)(2)(C).
[5] 42 U.S.C. § 1396b(m)(2)(B)(II), 42 C.F.R. § 483.2.
[6] *Id.*
[7] *Id.*
[8] Kaiser Commission on Medicaid and the Uninsured, *Distribution of Payments by Medicaid Enrollment Group 2009,* http://www.statehealthfacts.org/comparetable.jsp?ind=200&cat=4&sub=52&yr=90&typ=2 (last visited May 31, 2012): Kaiser Commission on Medicaid and the Uninsured, *Distribution of Medicaid Enrollees by Enrollment Group 2009,* http://www.statehealthfacts.org/comparetable.jsp?ind=200&cat=4&sub=52&yr=90&typ=2 (last visited May 31, 2012). Moreover, in 2009, while enrollees over age 65 comprised only 10% of the Medicaid population, they accounted for 23% of Medicaid spending. *Id.*
[9] 42 U.S.C. § 1396b(m)(1)(A)(i); 42 C.F.R. §§ 438.206(a), 438.207(a)(2), 438.210.

basis of health status or requirements for health services in enrollment, disenrollment, and re-enrollment.[10]

States must also ensure that the capitated rates themselves are adequate to cover necessary services for individuals enrolled in the MCO. States will not receive federal Medicaid matching funds for services provided by MCOs unless the services are provided pursuant to a contract under which payments are made on an actuarially sound basis. Actuarially sound rates, in general, are rates that are sufficient to ensure that all anticipated health care costs can be met.[11] States must document the actuarial certification of the capitation rates.[12] Notably, however, the U.S. Government Accountability Office has found that CMS has been inconsistent in reviewing states' rate setting practice for compliance with this requirement.[13]

Disability Discrimination Prohibitions

Despite these and other specific provisions intended to ensure access to necessary services, people with disabilities who are enrolled in managed care may also need the disability discrimination protections of Section 504 or the ADA.

Section 504 of the Rehabilitation Act prohibits "any program or activity" receiving federal funding from engaging in discrimination against people with disabilities.[14] This includes making reasonable accommodations so that services are accessible to people with disabilities, ensuring that facilities are accessible to people with disabilities and that services are provided in the most integrated setting appropriate to a person's needs.[15] This includes state Medicaid programs, which receive federal funds directly, as well as their successors, assignees, or transferees.[16] Specifically, health care providers that receive federal funding are bound by Section 504. This includes, for example, hospitals that receive Medicare and Medicaid payments, individual providers that are reimbursed by Medicaid, and HMOs that are paid with Medicaid or Medicare funds.[17]

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[10] 42 U.S.C. § 1396b(m)(1)(A); 42 C.F.R. § 438.700.

[11] The federal regulations define "actuarially sound capitation rates" as those developed "in accordance with generally accepted actuarial principles and practices, " certified as such, and are appropriate for the population to be covered and services furnished. 42 C.F.R. § 438.6(c)(1).

[12] 42 U.S.C. § 1396b(m)(1)(A); 42 C.F.R. § 438.700.

[13] U.S. Gov't Accountability Office, Medicaid Managed Care: CMS' Oversight of States' Rate Setting Needs Improvement (Aug. 2010), available at http://www.gao.gov/assets/310/308487.pdf.

[14] 29 U.S.C. §§ 794, 794a.

[15] 42 C.F.R. § 41.51(d), 45 C.F.R. § 84.4.

[16] 28 C.F.R. § 41.3(d).

[17] 45 C.F.R. § 84, App'x A, Subpart A, defs. 1, 2. *See also, e.g., U.S. v. Baylor Univ. Med. Ctr.,* 736 F.2d 1039, 1041-42 (5th Cir. 1984) (Medicare and Medicaid payments are federal financial assistance for Section 504 purposes); *Leslie v. Hee Man Chie,* 250 F.3d 47, 53 (1st Cir. 2001) (physician receiving Medicaid payments is a federal fund recipient); *Zamora-Quezada v. Health Texas Med. Group,* 34 F. Supp. 2d 433, 440 (W.D. Texas 2001) (section 504 applies to HMO receiving Medicare funds). If the only source of federal assistance an entity receives is Medicare Part B, that does not subject it to liability under Section 504, "because Medicare Part B—like other social security programs—is basically a program of payments to direct beneficiaries." 42 C.F.R. § 84, App'x A., subpt. A.

Title II of the Americans with Disabilities Act prohibits disability discrimination by public entities and in public services and programs. Like Section 504, Title II requires that entities make reasonable accommodations to ensure that individuals with disabilities can participate in public services and programs. It also requires that services be provided in the most integrated setting appropriate to an individual's needs. The U.S. Supreme Court has held, in *Olmstead v. L.C.,* that unjustified institutionalization violates Title II.[18]

State Medicaid agencies are public entities for Title II purposes, but managed care plans are not.[19] A public entity is defined as a State or local government; a department, agency, special purpose district, or *other instrumentality* of a State or States or local government. [20] Courts have held that "instrumentalities" are governmental units or entities created by one, thus private companies that contract with states would not meet this definition.[21] But, "all governmental activities of public entities are covered, even if they are carried out by contractors."[22] In addition, many states' standard Medicaid contracts require compliance with federal civil rights laws, including the ADA.[23]

Entities that do not receive any federal funding are usually bound by Title III of the ADA, which prohibits public accommodations from discriminating on the basis of disability in "the full and equal enjoyment" of their services and facilities.[24] A private business qualifies as a public accommodation if its operations affect interstate commerce. The definition specifically includes insurance offices, hospitals, and professional offices of health care providers.[25] Covered entities are prohibited from using eligibility criteria or methods of administration that screen out or exclude individuals because of their disability. They must make reasonable accommodations to ensure that individuals with disabilities can access the services or facilities of the entity and ensure that services be provided in the most integrated setting appropriate [26] Title III's physical accessibility requirements are more explicit than Title II, and require entities to remove architectural barriers that prevent access. The failure to take steps to ensure that no individual with a disability be excluded because of the lack of auxiliary aids and services, including qualified interpreters, also violated Title III.[27]

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[18] 527 U.S. 581 (1999).
[19] 42 U.S.C. § 12132.
[20] *Id.,* § 12131 (emphasis added).
[21] *See, e.g., Edison v. Douberly*, 604 F.3d 1307 (11th Cir. 2010)).
[22] 28 C.F.R., pt. 35, App. A.
[23] *See, e.g.,* N.Y. State Dep't of Health , Medicaid Managed Care and Family Health Plus Model Contract, J-2 (Mar. 1, 2011), http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_and_family_health_plus_model_contract.pdf
[24] 42 U.S.C. § 12182.
[25] 42 U.S.C. § 12181.
[26] *Id.,* § 12182(b)(2).
[27] *Id., see also* Mary R. Anderlik and Wendy J. Wilkinson, *The Americans with Disabilities Act and Managed Care*, 37 HOUSTON L. REV. 1163, 1185 (2000).

Case Examples

There are few published cases that address the obligations of Medicaid managed care organizations to comply with the ADA and Section 504. These cases generally deal with eligibility and access to services. For example individuals who were not eligible to enroll in Hawaii's QUEST program, which had more lenient financial eligibility requirements than the regular Medicaid program, sued, alleging that it was more difficult for people with disabilities to qualify for Medicaid than for others. The court held that this system violated the ADA and Section 504.[28]

Enrollees with disabilities have also experienced difficulty accessing services in managed care because of physical disabilities. For example, in *Anderson v. Dep't of Public Welfare*, plaintiffs, who had impaired vision and mobility, alleged that the state Medicaid agency failed to ensure that all providers in the mandatory managed care program practiced in offices that were accessible to PWD and to provide all information about managed care in alternative formats. The court denied summary judgment on most of the plaintiffs' claims, finding that there were numerous questions of material fact. Moreover, it held that the ADA did not require the state to ensure that every provider was accessible, only that people with disabilities should have meaningful ability to benefit from and participate in managed care.[29]

Not only do states have the ultimate responsibility for ensuring compliance with the ADA and Section 504, they also must ensure compliance with Medicaid requirements. To this end, States must designate a single state agency that administers and supervises the administration of the state Medicaid program.[30] Courts have recognized that, pursuant to this single state agency requirement, states retain ultimate responsibility for ensuring that MCOs comply with important Medicaid requirements such as covering necessary services with reasonable promptness. In *Tennessee Ass'n of Health Maintenance Orgs v. Grier,* Medicaid-participating MCOs argued that they were not bound by a long-standing Medicaid consent decree because they were not parties to the litigation when the consent decree went into effect. The Sixth Circuit disagreed, holding that they were bound by the decree because of their contractual obligations to the state. Moreover, the Court noted that they were agents of the state and were acting on behalf of the Medicaid agency, because the agency is the single state agency responsible for the administration of the Medicaid Act.[31]

In many cases, particularly when making a claim based on the ADA and Section 504's community integration mandate, it would not be efficacious to sue the managed care organization. The factors that lead to institutionalization, such as a lack of

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[28] *Burns-Vidlak by Burns v. Chandler,* 939 F. Supp. 765 (D. Haw. 1996).

[29] 1 F. Supp. 2d 456, 459-60 (E.D. Pa. 1998).

[30] 42 U.S.C. § 1396a(a)(5).

[31] 262 F.3d 559, 565 (6th Cir. 2001) *See also Carr v. Wilson-Coker,* 203 F.R.D. 66 (D. Conn. 2011) (notwithstanding the fact that the state contracts with MCOs, "its duties relative to ensuring that the plaintiffs receive medical services with reasonable promptness are non-delegable."); *J.K. v. Dillenberg,* 836 F. Supp. 694 (D. Ariz. 1996) ("It is patently unreasonable to presume that Congress would permit a state to disclaim federal responsibilities by contracting away its obligations to a private entity.")

community based waiver slots, provide reimbursement rates, cuts to community based services, are the result of state policy. Thus, even when MCOs are authorizing and providing services to plaintiffs, most, if not all, community integration litigation has been filed against the state Medicaid agency. For example, in *Crabtree v. Goetz,* enrollees in Tennessee's managed care system, TennCare, sued the state Medicaid officials, alleging that hard limits on in-home nursing violated the community integration mandate of Section 504 and the ADA. The Court granted a preliminary injunction, finding that the limits likely violated the ADA and Section 504, and the case ultimately settled.[32]

Courts have applied the requirements of Title III to managed care plans.[33] In a particularly interesting case, *Zamora-Quezada v. Health Texas Med. Group*, plaintiffs alleged that defendant HMOs denied or delayed provision of services to Medicare patients with disabilities in order to force these higher cost patients to go elsewhere. The ADA has a "safe harbor" provision that permits insurers and MCOs to make otherwise discriminatory risk underwriting and classifying decisions if they are based upon either sound actuarial principles or reasonably anticipated experience and are not a subterfuge to avoid liability under the ADA.[34] The HMOs argued that this safe harbor provision required dismissal of the suit. The court disagreed, questioning whether the decisions denying and delaying care were even related to underwriting practices. It further held that allowing the provision to insulate the HMOs from liability under the ADA would be contrary to Medicare's prohibition on discrimination on the basis of health status.[35]

Advocacy tips

If your state is considering or in the process of implementing managed care for PWD, advocate to ensure that managed care contracts require compliance with the ADA and Section 504, as well as other civil rights laws.

Monitor written managed care materials to determine whether they are accessible to people with visual impairments and visit network provider sites to ensure that they are physically accessible.[36]

If people with disabilities are experiencing disability discrimination, keep in mind that the state must ensure that MCOs comply with the ADA, Section 504, and the required by the single state agency requirement, 42 U.S.C. § 1396a(a)(5), to ensure that plans comply with Medicaid and other legal requirements.

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[32] *Crabtree v. Goetz,* No. 3:08-0939, 2008 WL 5330506 (M.D. Tenn. Dec. 19, 2008).
[33] 34 F. Supp. 2d 433 (W.D. Texas 2001). Plaintiffs also brought Section 504 claims against the HMOs because they received Medicare payments.
[34] 42 U.S.C. § 12201(c).
[35] 34 F. Supp. 2d at 443-444, citing 42 U.S.C. § 1395mm(c)(3)(D).
[36] For information about public reporting requirements for states and Medicaid MCOs, *see* Jane Perkins, *Assuring Accountability and Stewardship in Medicaid Managed Care: Public Reporting Requiremenst for States and MCOs* (May 31, 2007) (available from TASC).