



# **INCREASING THE PHYSICAL ACCESSIBILITY OF HEALTH CARE FACILITIES**

**May 2017**



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# Introduction

Despite federal requirements that health care providers ensure equal access to programs, services, and facilities for people with disabilities, physical accessibility remains a considerable challenge. One of the most prominent challenges for people with physical disabilities is overcoming the barriers to entering and navigating health care facilities, including inaccessible entrances, hallways, examination rooms, medical equipment, and restrooms.

This brief provides an overview of why physical accessibility of health care facilities is important for people with disabilities. It discusses the laws enacted to promote accessibility and provides examples of federal and state-level efforts to increase accessibility. Lastly, it offers suggestions for improving physical accessibility of health care facilities on a broader scale.

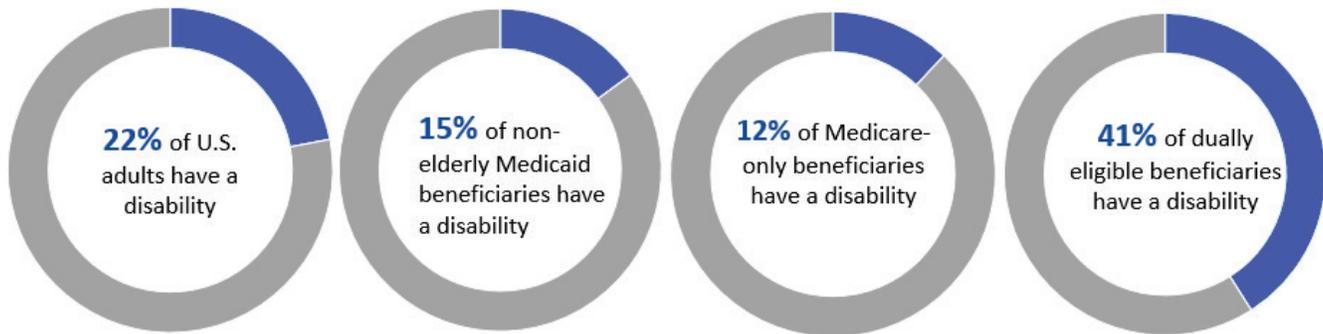
## KEY WORDS

disability; health disparities; accessibility; physical accessibility; enforcement and compliance

# Background

Many Americans today have disabilities, whether congenital, temporary, or developed later in life.<sup>1</sup> According to the 2013 Behavioral Risk Factor Surveillance Survey (BRFSS), 22.2 percent of U.S. adults reported having a disability, with mobility-related disability being the most frequently reported type (13 percent).<sup>2</sup> As more baby boomers become seniors, the proportion of Americans with disabilities is expected to grow,<sup>3</sup> especially the proportion with mobility disabilities.<sup>4</sup> A 2012 analysis of the American Community Survey found that the prevalence of disability was 25 percent among people ages 65 to 74 and 50 percent among people ages 75 and older.<sup>5</sup> Among the Medicare-only population, approximately 12 percent of beneficiaries have a disability; among those dually eligible for both Medicare and Medicaid, approximately 41 percent have a disability.<sup>6</sup> Among the more than 68.9 million citizens who rely on Medicaid, 15 percent—or 10.2 million—are non-elderly people with disabilities.<sup>7</sup> Prevalence of disability varies across racial and ethnic groups. Data from the BRFSS indicate that overall, more non-Hispanic black adults (29.0 percent) and Hispanic adults (25.9 percent) than white non-Hispanic adults (20.6 percent) reported having a disability.<sup>8</sup>

## Prevalence of Disabilities in the U.S.



Sources: Centers for Disease Control and Prevention, 2013; Centers for Medicare & Medicaid Services (CMS), 2015; CMS, 2013

Adults with disabilities are almost twice as likely as other adults to report unmet health care needs due to problems with the accessibility of a doctor's office or clinic.<sup>9</sup> Structural, financial, and cultural barriers persist for people with disabilities when trying to access care.<sup>10</sup> Many individuals with mobility disabilities face difficulties locating or otherwise traveling a burdensome distance to physically accessible services.<sup>11</sup>

Providing equal access to health care for people with physical disabilities involves many factors including, but not limited to:

- ▶ **Facility access.** This includes accessible routes from parking or bus stops into the building, accessible parking, accessible entry doors with the required clearance width, clear floor space, and maneuvering clearance, accessible restrooms, and accessible signage for people who are blind or have low vision.<sup>12</sup>
- ▶ **Health care services access.** This includes accessible scales and exam tables to facilitate a medical exam, accessible treatment and diagnostic equipment (including infusion chairs, mammography machines, and radiology equipment), appropriate resources for individuals with visual and auditory disabilities, and staff trained to assess patient needs and safely help patients move in between and transfer on and off medical equipment.

Studies have found that while progress has been made toward improving accessibility into and within medical buildings, patients continue to confront many barriers inside physician suites.<sup>13, 14, 15, 16</sup> A recent study of subspecialty practices in four U.S. cities found that 22 percent of practices reported being unable to accommodate a patient in a wheelchair.<sup>17</sup> Inaccessible exam tables, weight scales, infusion chairs, mammography machines, and radiology equipment all impact treatment for people with disabilities and may impact personal safety.<sup>18</sup> Health care workers may face occupational safety issues when assisting persons with disabilities, e.g., patient transfer and positioning.<sup>19</sup> No recent studies have focused on physical barriers to care specifically for people with disabilities of different racial and ethnic backgrounds. However, an older study of access to care in Los Angeles County among individuals with physical or sensory disabilities found that 33 percent of non-Hispanic black adults reported difficulty accessing a

health care provider's office because of its physical layout or location, compared with 14.4 percent of non-Hispanic white adults.<sup>20</sup>

## Ensuring Accessibility of Health Care Facilities: Laws & Regulations

This section provides a summary overview of several key antidiscrimination provisions and legal regulations protecting the right of equal access to health care for people with disabilities. These include Section 504 of the Rehabilitation Act of 1973 (Section 504)<sup>21</sup> and Titles II<sup>22</sup> and III<sup>23</sup> of the Americans with Disabilities Act (ADA).<sup>24, 25, 26</sup> Specifically:

- ▶ Title II of the ADA requires covered public entities to provide equal access to programs, services, and activities when considered as a whole for individuals with disabilities. The Title II regulations and ADA Standards for Accessible Design include specific requirements regarding new construction and alterations to buildings and facilities, including health care facilities, as well as requirements for service animals, communications, and telecommunications. For existing facilities that are not accessible, program access requirements under Title II allow public entities the option to relocate programs or to provide accessible services at other locations.<sup>27</sup>
- ▶ Title III of the ADA applies to certain categories of private entities known as “places of public accommodation.” The definition of such places includes a “professional office of a health care provider, hospital, or other service establishment.” With certain limitations, Title III and its regulations require medical providers to provide equal services to individuals with disabilities, to make reasonable modifications in policies and practices where necessary to provide equal access, and to provide auxiliary aids and services when necessary to provide effective communication. Title III also requires removal of architectural barriers at existing facilities where barrier removal is readily achievable, and compliance with the ADA Standards for Accessible Design for new construction and alterations to existing facilities.<sup>28</sup>
- ▶ Section 504 prohibits discrimination on the basis of disability by any program or activity receiving federal financial assistance. It requires compliance with specific standards for design and construction of new facilities and ensures the accessibility of programs as a whole.

Multiple government entities are involved in regulating accessibility protections. Each has a range of mechanisms at hand for enforcing physical accessibility requirements. Various federal agencies provide resources, information, and—in some cases—funding to promote improved accessibility for people with disabilities.

The U.S. Architectural and Transportation Barriers Compliance Board (Access Board), established by Section 502 of the Rehabilitation Act,<sup>29</sup> is an independent federal agency that promotes equality for people with disabilities through leadership in accessible design and the development of accessibility guidelines and standards. The Access Board is charged with

developing and updating the ADA Accessibility Guidelines (ADAAG), among other responsibilities. The ADA requires the Department of Justice (DOJ) to promulgate regulations that include enforceable accessibility standards that are consistent with the minimum guidelines issued by the Access Board. However, DOJ may adopt scoping or technical standards that provide greater accessibility than the guidelines developed by the Access Board. In 2010, DOJ issued updated ADA Standards for Accessible Design with detailed requirements for accessibility of buildings and facilities. The Department of Veterans Affairs (VA) has also issued guidelines on ensuring similar accessibility in VA buildings. In January 2017, the Access Board issued final, non-binding accessibility standards for medical diagnostic equipment, including but not limited to, examination tables, examination chairs, weight scales, mammography equipment, and other imaging equipment health care providers use for diagnostic purposes.<sup>30</sup> The VA has since announced an acquisitions policy that will require that new equipment purchases across the VA Health system, including its 152 medical centers and 800 community-based outpatient clinics, meet these standards for medical diagnostic equipment.<sup>31</sup>

The DOJ promotes health care accessibility through the “Barrier-Free Health Care Initiative,” which enhances collaboration between the DOJ’s Civil Rights Division and U.S. Attorney’s offices across the country to target enforcement efforts.<sup>32</sup> DOJ enforces the ADA’s requirements for equal access to health care services through mediation, investigations, and litigation. DOJ also operates a 1-800 hotline for questions and technical assistance involving the Americans with Disabilities Act and manages [www.ada.gov](http://www.ada.gov).

The U.S. Department of Health and Human Services (HHS) and its health care programs offer important resources to help improve the physical accessibility of health care facilities and services. In addition to providing guidelines and technical information on compliance, the HHS Office for Civil Rights (OCR) enforces Title II of the ADA and Section 504 by conducting investigations of health care providers and medical facilities, providing technical assistance, and initiating voluntary compliance efforts and enforcement actions.

Table 1 below summarizes the major federal laws, regulations, and standards governing the accessibility of health care facilities and programs, including a brief summary of the requirements of each and to which entities each applies.

**Table 1: Summary of Major Federal Laws and Regulations for Accessibility**

Federal Law/Regulation	Summary	Applies to
<b>Americans with Disabilities Act (ADA)—1990</b> (42 U.S.C. §§ 12101–12213)	<ul style="list-style-type: none"> <li>▶ Prohibits discrimination on the basis of disability: this includes adhering to the ADA Standards for new construction and alterations; complying with applicable provisions for existing facilities; communicating effectively with people with disabilities; and making reasonable modifications to policies and procedures to avoid discrimination.</li> <li>▶ Compliance is required unless it would result in an undue burden or fundamental alteration.<sup>33</sup></li> <li>▶ Statute and regulations specifically mention medical facilities.</li> </ul>	State and local government programs (Title II), private health care providers (Title III)

Federal Law/Regulation	Summary	Applies to
<b>Section 504 of Rehabilitation Act—1973</b> (29 U.S.C. § 792 et seq.)	<ul style="list-style-type: none"> <li>▶ Adopts requirements for accessibility of exterior and interior structural elements of newly constructed or altered facilities.</li> <li>▶ “No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives Federal financial assistance.”<sup>34</sup></li> <li>▶ Small providers are not required to make significant structural alterations to their existing facilities for the purpose of assuring program accessibility if alternative means of providing the services are available.<sup>35</sup></li> <li>▶ The Rehabilitation Act also created the U.S. Access Board, an independent federal agency that creates minimum guidelines, standards, criteria, technical assistance, and training on the accessible design of facilities, telecommunications equipment, medical diagnostic equipment, and information technology.<sup>36, 37, 38, 39</sup></li> <li>▶ The U.S. Access Board released non-binding final accessibility standards for medical diagnostic equipment in January 2017.<sup>40</sup></li> </ul>	All programs and activities that receive federal financial assistance
<b>Medicare conditions of participation</b> (42 CFR §§ 482–485)	<ul style="list-style-type: none"> <li>▶ Providers are required to comply with “Federal, State and local laws.”</li> <li>▶ CMS may rely on states or state survey agencies to make recommendations to CMS regarding provider eligibility or may deem providers to be in compliance based on approved accreditation standards.<sup>41</sup></li> </ul>	Medicare providers—explicitly applies to hospitals, long-term-care facilities, outpatient rehabilitation, providers of outpatient physical therapy, and community mental health centers <sup>42</sup>
<b>Medicare survey and certification process</b> (42 CFR § 488)	<ul style="list-style-type: none"> <li>▶ The survey and certification process, overseen by CMS and conducted by states, is intended to verify how well health care facilities comply with the Medicare Conditions of Participation.</li> <li>▶ To verify compliance with civil rights laws, health care facilities submit electronically an attestation of compliance—with Section 504 and other statutes—to OCR before CMS processes requests for initial or change of ownership surveys.</li> <li>▶ This process does not cover physician’s offices or clinics with which Medicare contracts. Additionally, states may exempt providers from routine surveys if they are accredited by an approved national accreditation organization.<sup>43, 44</sup></li> </ul>	Providers of services or providers means a hospital, critical access hospital, skilled nursing facility, nursing facility, home health agency, hospice, comprehensive outpatient rehabilitation facility, or provider of outpatient physical therapy or speech pathology services. <sup>45</sup>
<b>Medicare Advantage (MA) contract requirements</b> (42 CFR § 422)	<ul style="list-style-type: none"> <li>▶ MA organizations may not discriminate and must ensure that individuals with disabilities have effective means of communication.</li> <li>▶ Requirements do not explicitly require MA organizations to comply with ADA or Section 504.</li> <li>▶ MA organizations must have written policies for selecting providers that conform to all contract requirements and must have a compliance program in place to prevent, detect, and correct noncompliance.</li> </ul>	Medicare Advantage health plans
<b>Medicaid managed care requirements</b> (42 CFR § 438)	<ul style="list-style-type: none"> <li>▶ States are responsible for ensuring that all Medicaid managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), primary care case managers (PCCMs), and PCCM entities comply with the ADA, the Rehabilitation Act, and other requirements. States are responsible for ensuring that all MCOs, PIHPs, and PAHPs maintain an adequate network of providers that provide physical access for enrollees with disabilities.</li> </ul>	Medicaid managed care plans

# Mechanisms for Increasing Accessibility

As noted above, despite laws to ensure equitable treatment of people with disabilities, barriers to accessing health care persist. Below, we discuss challenges providers and policymakers face, provide examples of federal and state-level efforts to increase accessibility, and outline potential solutions for improving physical accessibility of health care facilities on a broader scale.

## UNDERSTANDING THE NEEDS OF PEOPLE WITH DISABILITIES

To address the issue of physical accessibility of health care facilities, it is important to understand the extent to which the health care system is meeting the needs of individuals with disabilities. Most population-level data sources seek only to identify respondents with disabilities. Data on the needs and experiences of people with disabilities is limited, particularly with respect to physical accessibility.

There are some promising opportunities to collect data on patient needs. Under the ACA, Medicare covers an Annual Wellness Visit, which includes a health risk assessment (HRA). While there is no standard HRA model, at a minimum, the HRA is required to include questions about activities of daily living/instrumental activities of daily living (ADLs/IADLs).<sup>46</sup> As part of the CMS Financial Alignment Initiative (FAI), Medicare-Medicaid Plans (MMPs) are generally required to conduct HRAs within two to three months of enrolling a beneficiary in a demonstration MMP.<sup>47</sup> The specific requirements and questions vary from state to state but often include information on beneficiaries' need for assistance in terms of ADLs/IADLs. The annual assessment requirement in the FAI may provide new avenues to understand and address physical accessibility needs by collecting additional data from MMP enrollees and ensuring plan compliance. Similarly, Medicare Advantage plans, including Special Needs Plans (SNPs), are also required to conduct HRAs.<sup>48</sup> Medicare Advantage SNPs are coordinated care plans that target enrollment and care to beneficiaries who have a disabling chronic condition (C-SNP), are dually eligible for Medicare and Medicaid (D-SNP), or are institutionalized (I-SNP).

Providers could also capture more information in electronic health records at the point of care—offering the opportunity to better anticipate patient and consumer needs. Providers and staff could collect information on functional limitations or accessibility needs when making appointments, add this information to patients' medical records, and verify the information when patients appear for care.<sup>49</sup> Collecting this information when patients schedule appointments would help prepare providers and their staff to better meet patients' needs and ultimately improve the quality of care provided for persons with physical disabilities.<sup>50</sup>

## MONITORING AND REPORTING INFORMATION ON ACCESSIBILITY

Information on the physical accessibility of health care facilities and services is limited. Currently there are no national-level data. However several states collect data to monitor provider accessibility, mostly through their Medicaid programs, including Section 1115 Medicaid demonstration waivers. For example, Massachusetts, New York, and Nevada all have detailed policies and/or oversight processes to ensure that the providers contracted by their managed

care organizations comply with federal accessibility and antidiscrimination standards. California mandated that all Medicaid health plans conduct a site review of each of their primary care provider's sites to evaluate accessibility using a standardized tool as required by the state's Section 1115 demonstration.<sup>51, 52</sup> Similarly, Massachusetts requires all Medicaid-contracted providers to complete the Massachusetts Facility Assessment tool through the state's procurement process.<sup>53</sup> In New York, managed care organizations are required to submit an "ADA Compliance Plan" to the state describing in detail how they will make services readily accessible to individuals with disabilities, either through their network of providers or through out-of-network care.<sup>54</sup> Finally, Nevada's Medicaid Operations Manual confirms the state's responsibility to ensure that all health care facilities, including public health and private providers that accept government funding, comply with the Rehabilitation Act and the ADA.<sup>55</sup> Network adequacy standards have been another vehicle for gathering relevant accessibility data. Washington state network adequacy rules require providers to include information about the physical accessibility of the provider's facilities. New Mexico also requires its managed care plans to provide a description of the physical accessibility of the provider network for people with disabilities.<sup>56</sup>

Through the capitated Financial Alignment Initiative dual-eligible demonstration, CMS and each participating state\* and health plan enter into three-way contracts prior to implementation, which include detailed disability access expectations for the health plans and their providers. The demonstration also requires policy assessments to determine readiness and regular monitoring during the demonstration period. For example, four states (California, Illinois, Virginia, and Michigan) use reporting requirements to monitor compliance related to the ADA or physical accessibility; these include requiring each participating health plan to have a Physical Access Compliance Policy and a staff member responsible for ADA compliance.<sup>57</sup>

Regulations included in the 2016 Medicaid managed care final rule provide a framework for scaling up data collection efforts currently underway in a small number of states.<sup>58</sup> First, the rule requires that Medicaid managed care plans' provider directories include information on the accessibility of network provider offices/facilities. Second, the rule directs states to develop and enforce network adequacy standards that consider the "ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities."<sup>59</sup> Last, the rule requires that states ensure that managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans comply with their contract requirement to ensure that network providers "provide physical access, accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities."<sup>60</sup> The ACA provides additional broad guidance about network adequacy standards for health plans, but does not specifically address physical accessibility for people with disabilities.<sup>61,62</sup>

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\* The following states are participating in the capitated FAI demonstration: California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas, and Virginia.

## **REDUCING FINANCIAL BARRIERS FOR PROVIDERS**

Financial barriers prevent many providers from improving the accessibility of their facilities.<sup>63</sup> The purchase of new equipment to meet accessibility requirements and the cost of new equipment can be restrictive for smaller practices. In addition to purchasing new equipment, there is the cost of additional staff training to ensure that they can operate the equipment safely, further taxing offices' limited administrative budgets.

Tax incentives are available at the federal and state level to offset the cost of improving facility accessibility. At the federal level, the Internal Revenue Service (IRS) administers the Disabled Access Credit to eligible small businesses, including some health care providers, for the purchase of equipment or auxiliary aids and for removing barriers in existing facilities.<sup>64, 65</sup> The IRS also oversees the Federal Tax Deduction to Remove Architectural and Transportation Barriers to People with Disabilities and Elderly Individuals.<sup>66</sup> Tax credits or deductions are limited to a specific amount each year. Some states, such as California, offer additional tax incentives to complement federal incentives.<sup>67</sup>

CMS recently proposed changes to physician payment for services they provide for individuals with mobility disabilities.<sup>68</sup> The proposed rule to update the Medicare Physician Fee Schedule for Calendar Year 2017 included a new payment code to recognize the increased resource costs associated with the medically necessary use during an office visit of specialized mobility-assistive technology, such as adjustable height chairs or tables, patient lifts, and adjustable padded leg supports. Although CMS received many supportive comments from the public, some commenters raised concerns regarding unintended consequences of the new payment code, such as the application of cost-sharing requirements for these services. CMS did not finalize payment for the code; instead, the agency intends to engage with interested beneficiaries, advocates, and providers to continue to explore improvements in payment accuracy for care of people with mobility disabilities. CMS intends to reconsider the issue later and may address in future rulemaking.

## **INCREASING PROVIDER AWARENESS AND TRAINING**

There is a clear need for increased awareness among medical professionals and staff on how to increase access to care and improve quality of care for individuals with disabilities.<sup>69</sup> The Urban Institute's Health Reform Monitoring Survey showed that 24.2 percent of adults with disabilities reported experiencing disrespectful treatment or felt judged unfairly. In comparison, only 8.1 percent of the general population reported experiencing this disrespectful treatment.<sup>70</sup> Professionals' limited knowledge about how to accommodate persons with disabilities contributes to the barriers described above. Even in settings with new, compliant medical equipment, staff may not have adequate knowledge on engaging with patients with disabilities and assessing patient needs, or on how to best use the equipment.<sup>71</sup>

Training programs for health care providers and administrators may encourage strategies for effectively understanding and meeting beneficiary needs. The training programs offered to

providers in the Financial Alignment Initiative could serve as models.<sup>†</sup> In general, when working to ensure equitable care for people with disabilities, person-centered care—defined by the Institute of Medicine as “care that is respectful of and responsive to individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions”—may also serve as a model for ensuring equitable care for individuals with disabilities.<sup>72</sup> The process for person-centered planning in health care supports individual preferences and needs and ensures that each person is central to the health planning process. Several parts of this process are crucial for implementation. For example, individuals should be in control over the process and allowed to make key decisions, the process should be convenient to the person and any family/representatives, and each person should be able to indicate cultural preferences.<sup>73</sup>

## Conclusion

People with disabilities often face significant barriers in accessing essential health care services. The inaccessibility of provider offices and medical facilities is an important contributing factor to the wide health care disparities experienced by people with disabilities. Structural obstacles, inaccessible medical equipment, and restrictive policies and procedures can render basic and specialty health services inaccessible and can result in negative care experiences and/or delays in seeking necessary care for this population. Federal laws and antidiscrimination provisions, including the ADA and Section 504 of the Rehabilitation Act, set standards for health care providers to ensure equitable access to services for people with disabilities. However, providers may not have knowledge of resources or incentives to remove accessibility barriers. Nevertheless, many opportunities exist to increase accessibility, both at the state and federal levels. Raising the level of awareness among providers on this problem and potential solutions is a critical first step toward increasing physical accessibility of health care services. Such initiatives, along with other incentives, will help achieve the promise of equal access to care and contribute to reducing health disparities for people with disabilities.

### SUGGESTED CITATION

Singer, RF, I Dickman, A Rosenfeld. Increasing the Physical Accessibility of Health Care Facilities. CMS OMH Issue Brief. Baltimore, MD: CMS Office of Minority Health. (2017).

## References

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<sup>1</sup> The Centers for Medicare and Medicaid Services, Office of Minority Health (CMS OMH) cannot attest to the accuracy of non-federal websites. The link to any non-federal website below does not constitute an endorsement by CMS OMH or any of its employees of the sponsors or the information and products presented on the non-federal website. CMS OMH proudly complies with Section 508 accessibility regulations, but we cannot be responsible for Section 508 accessibility on non-federal websites.

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<sup>†</sup> See the Resources for Integrated Care website: <https://www.resourcesforintegratedcare.com/>.

- <sup>2</sup> Centers for Disease Control and Prevention. “Prevalence of Disability and Disability Type among Adults—United States, 2013.” *Morbidity and Mortality Weekly Report*. (2013). <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6429a2.htm#tab1>.
- <sup>3</sup> Iezzoni, L. I. “Eliminating Health and Health Care Disparities among the Growing Population of People with Disabilities.” *Health Affairs* 30(10): 1947–1954. (2011).
- <sup>4</sup> Erickson, W., C. Lee & S. von Schrader. *2012 Disability Status Report: United States*. Ithaca, NY: Cornell University Employment and Disability Institute. (2014). [http://www.disabilitystatistics.org/StatusReports/2012-PDF/2012-StatusReport\\_US.pdf](http://www.disabilitystatistics.org/StatusReports/2012-PDF/2012-StatusReport_US.pdf).
- <sup>5</sup> Erickson, W., C. Lee & S. von Schrader. (2014).
- <sup>6</sup> Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office. “Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006 through 2011.” (2013). [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual\\_Enrollment\\_2006-2011\\_Final\\_Document.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Enrollment_2006-2011_Final_Document.pdf)
- <sup>7</sup> Centers for Medicare & Medicaid Services. CMS Statistics Reference Booklet- 2015 edition. (2015). <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/index.html>.
- <sup>8</sup> Centers for Disease Control and Prevention. “Key Findings: Prevalence of Disability and Disability Type among Adults, United States—2013.” *Disability and Health*. (2013). <http://www.cdc.gov/ncbddd/disabilityandhealth/features/key-findings-community-prevalence.html#BRFSS>.
- <sup>9</sup> Karpman, M. & Long, S.K., Urban Institute, Health Reform Monitoring Survey. “QuickTake: Even with Coverage, Many Adults Have Problems Getting Health Care, with Problems Most Prevalent among Adults with Disabilities.” (2015). <http://hrms.urban.org/quicktakes/Many-Adults-Have-Problems-Getting-Health-Care.html>
- <sup>10</sup> Blick, R., et. al. “The Double Burden: Health Disparities among People of Color Living with Disabilities.” Ohio Disability and Health Program. (2015). [http://nisonger.osu.edu/sites/default/files/u4/the\\_double\\_burden\\_health\\_disparities\\_among\\_people\\_of\\_color\\_living\\_with\\_disabilities.pdf](http://nisonger.osu.edu/sites/default/files/u4/the_double_burden_health_disparities_among_people_of_color_living_with_disabilities.pdf)
- <sup>11</sup> Krahn, G. L., D. K. Walker, & R. Correa-De-Araujo. “Persons with Disabilities as an Unrecognized Health Disparity Population.” *American Journal of Public Health* 105(S2). (2015).
- <sup>12</sup> Department of Justice and Department of Health and Human Services. “Access to Medical Care for Individuals with Mobility Disabilities,” (2010). [https://www.ada.gov/medicare\\_mobility\\_ta/medicare\\_ta.pdf](https://www.ada.gov/medicare_mobility_ta/medicare_ta.pdf).
- <sup>13</sup> Mudrick N. R., M. L. Breslin J. I. Kailes. “Response to the Data Challenges of the Affordable Care Act: Surveys of Providers to Assess Access to Care for People with Disabilities and the Presence of Accessible Exam Equipment.” *School of Social Work*. Paper 1. (2011). <http://surface.syr.edu/swk/1>.
- <sup>14</sup> McNeal, M., Carrothers, A. L. and B. Premo. “Providing Primary Health Care for People with Physical Disabilities: A Survey of California Physicians.” Center for Disability Issues and the Health Professions. (2002). <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.189.5390&rep=rep1&type=pdf>
- <sup>15</sup> Lagu T., N. S. Hannon, M. B. Rothberg, et al. “Access to Subspecialty Care for Patients with Mobility Impairment: A Survey.” *Annals of Internal Medicine* 158:441–446. (2013).
- <sup>16</sup> Mudrick, N. R., M. L. Breslin & M. Liang. “Physical Accessibility in Primary Health Care Settings: Results from California On-Site Reviews.” *Disability and Health Journal* 5(3):159–167. (2012).
- <sup>17</sup> Lagu et al. “Access to Subspecialty Care for Patients.” (2013).
- <sup>18</sup> Iezzoni, L. I. “Eliminating Health and Health Care Disparities among the Growing Population of People with Disabilities.” *Health Affairs* 30(10): 1947–1954. (2011).
- <sup>19</sup> Centers for Disease Control and Prevention. “Safe Patient Handling and Movement (SPHM).” The National Institute for Occupational Safety and Health (NIOSH). (2016). <http://www.cdc.gov/niosh/topics/safepatient/default.html>
- <sup>20</sup> Centers for Disease Control and Prevention. “Environmental Barriers to Health Care among Persons with Disabilities: Los Angeles County, California, 2002–2003.” *Morbidity and Mortality Weekly Report*. 55(48):1300–1303. (2006).
- <sup>21</sup> 29 U.S.C. § 794.

- <sup>22</sup> 42 U.S.C. §§ 12131-12134.
- <sup>23</sup> 42 U.S.C. §§ 12181-12189.
- <sup>24</sup> Americans with Disabilities Act of 1990. <https://www.ada.gov/pubs/adastatute08.pdf>.
- <sup>25</sup> Public Law 111–148, 124 Stat. 570.
- <sup>26</sup> 42 U.S.C. § 18116.
- <sup>27</sup> Title II of the ADA is enforced by the U.S. Department of Justice, Civil Rights Division, Disability Rights Section, and the HHS Office for Civil Rights. The Title II regulations are set forth at 28 C.F.R. Part 35.
- <sup>28</sup> 28 C.F.R. § 36.302.
- <sup>29</sup> 29 U.S.C. § 792.
- <sup>30</sup> Standards for Accessible Medical Diagnostic Equipment 82 Fed. Reg. 5 (January 9, 2017) (to be codified at 36 C.F.R. pt. 1195).
- <sup>31</sup> U.S. Access Board. VA Adopts New Standards for Medical Diagnostic Equipment. Access Currents: March/April 2017. (2017). <https://www.access-board.gov/news/access-currents-march-april-2017>.
- <sup>32</sup> Department of Justice. “Justice Department Announces Americans with Disabilities Act Barrier-free Health Care Initiative by US Attorney’s Offices Nationwide.” (2012). <http://www.justice.gov/opa/pr/justice-department-announces-americans-disabilities-act-barrier-free-health-care-initiative>.
- <sup>33</sup> Department of Justice. “Definition of ‘Undue Burden’ in Section 36,104 of ‘ADA Title III Regulation 28 CFR Part 36.’” <http://www.ada.gov/reachingout/l2factors.html>.
- <sup>34</sup> 45 C.F.R. Part 84.
- <sup>35</sup> 45 C.F.R. § 84.22.
- <sup>36</sup> Department of Justice. “2010 ADA Standards for Accessible Design.” (2010). [https://www.ada.gov/2010ADASTandards\\_index.htm](https://www.ada.gov/2010ADASTandards_index.htm).
- <sup>37</sup> Department of Justice. “Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities.” Final Rule of September 15, 2010. *Federal Register* 75(178). <https://www.federalregister.gov/articles/2010/09/15/2010-21824/nondiscrimination-on-the-basis-of-disability-by-public-accommodations-and-in-commercial-facilities>.
- <sup>38</sup> Department of Justice. “Nondiscrimination on the Basis of Disability in State and Local Government Services.” (2010).
- <sup>39</sup> United States Access Board. “About the ADA Standards.” <https://www.access-board.gov/guidelines-and-standards/buildings-and-sites/about-the-ada-standards>.
- <sup>40</sup> Standards for Accessible Medical Diagnostic Equipment 82 Fed. Reg. 5 (January 9, 2017)
- <sup>41</sup> 42 C.F.R. Part 488.
- <sup>42</sup> 42 C.F.R. Part 482.
- <sup>43</sup> 42 C.F.R. Part 488.
- <sup>44</sup> Centers for Medicare & Medicaid Services. “Survey & Certification—General Information.” (2013). <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/>.
- <sup>45</sup> 42 C.F.R. Part 488.
- <sup>46</sup> Centers for Medicare & Medicaid Services. “Medicare Program; Payment Policies Under the Physician Fee Schedule, Five-Year Review of Work Relative Value Units, Clinical Laboratory Fee Schedule: Signature on Requisition, and Other Revisions to Part B for CY 2012.” Federal Register Final Rule. (November 28, 2011). <https://www.gpo.gov/fdsys/pkg/FR-2011-11-28/pdf/2011-28597.pdf>
- <sup>47</sup> Medicaid and CHIP Payment and Access Commission. “Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare.” Washington, DC. (2015). <https://www.macpac.gov/wp-content/uploads/2015/09/Financial-Alignment-Initiative-for-Beneficiaries-Dually-Eligible-for-Medicaid-and-Medicare.pdf>
- <sup>48</sup> Centers for Medicare & Medicaid Services. “Attachment IX: Special Needs Plans—Model of Care Implementation Audit Process and Universe Request.” <https://www.cms.gov/medicare/compliance-and-audits/part-c-and-part-d-compliance-and-audits/downloads/attachment-ix-snp-moc-audit-process-and-universe-request.pdf>

- <sup>49</sup> Disability Rights Education & Defense Fund. “Health Disparity Research and Data Collection.” Draft Memorandum on Section 4302 of the Patient Protection and Affordable Care Act (ACA): Disability-related Data Collection. (2011). <https://dredf.org/wp-content/uploads/2012/08/DRAFT-4302-DATA-MEMORANDUM-4.11.pdf>.
- <sup>50</sup> Disability Rights Education & Defense Fund. “Health Disparity Research and Data Collection.” (2011).
- <sup>51</sup> California Department of Health Care Services, Medi-Cal Managed Care Division. “Physical Accessibility Review Survey.” (2011). <https://www.ccah-alliance.org/PReview/PAR-tool-2011.pdf>.
- <sup>52</sup> California Department of Health Care Services. “Revised Facility Site Review Tool.” MMCD Policy Letter 12-006. (2012). <http://www.ccah-alliance.org/PReview/PL-12-006-PAR.pdf>.
- <sup>53</sup> Massachusetts Department of Public Health, Office on Health and Disability. “The Massachusetts Department of Public Health Contractor Guidelines for Required ADA Compliance.” (2010). <http://www.mass.gov/eohhs/docs/dph/health-equity/guide-mdph-contracted-providers.pdf>.
- <sup>54</sup> McSilver Institute for Poverty Policy and Research. “Managed Care Technical Assistance Center Kick-Off Forum FAQs.” (2015). <http://www.ctacny.org/sites/default/files/trainings-pdf/2014-1-23-MCTAC-Kick-off-FAQs.pdf>.
- <sup>55</sup> Liveratti, John A., Nevada Department of Health and Human Services, Division of Health Care Financing and Policy “Medicaid Operations Manual Changes.” Memorandum to Custodians of Medicaid Operations Manuals. (2004). [http://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Resources/AdminSupport/Manuals/MOM/MOM\\_Ch300\\_04\\_02-26.pdf](http://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Resources/AdminSupport/Manuals/MOM/MOM_Ch300_04_02-26.pdf).
- <sup>56</sup> Families USA, Standards for Health Insurance Provider Networks, examples from the states, November 2014. [http://familiesusa.org/sites/default/files/product\\_documents/ACT\\_Network%20Adequacy%20Brief\\_final\\_web.pdf](http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf).
- <sup>57</sup> Centers for Medicare & Medicaid Services. “Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements.” (2015). <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2015ReportingAppendixCA.pdf>.
- <sup>58</sup> Centers for Medicare & Medicaid Services. “Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability.” Federal Register Final Rule. (May 6, 2016). <https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>.
- <sup>59</sup> Federal Register. 2015. 42 C.F.R. § 438.68 (c)(viii); 80 Fed. Reg. at 31271.
- <sup>60</sup> Federal Register. 2015. 42 C.F.R. § 438.206 (c)(3); 80 Fed. Reg. at 31275.
- <sup>61</sup> Cornell University Law School. 42 U.S. Code § 18031— Affordable Choices of Health Benefit Plans. <https://www.law.cornell.edu/uscode/text/42/18031>
- <sup>62</sup> Federal Register. 2016. 19 45 CFR § 156.230; 81 Fed. Reg. at 12203.
- <sup>63</sup> Lagu, T., L. I. Iezzoni & P. Lindenauer. “The Axes of Access—Improving Care for Patients with Disabilities.” *New England Journal of Medicine* 370(19):1847–1851. (2014).
- <sup>64</sup> Adaptive Environments Center. “Fact Sheet 4. Tax Incentives for Improving Accessibility.” Developed for the National Institute on Disability and Rehabilitation Research. (1992). <http://www.ada.gov/archive/taxpack.pdf>.
- <sup>65</sup> 26 U.S.C. § 44.
- <sup>66</sup> Internal Revenue Service. “Costs You Can Deduct or Capitalize.” (2015). [https://www.irs.gov/publications/p535/ch07.html#en\\_US\\_2015\\_publink1000208925](https://www.irs.gov/publications/p535/ch07.html#en_US_2015_publink1000208925)
- <sup>67</sup> Center for Disability Issues and Health Professions. “Tax Incentives for Improving Accessibility.” Western University of Health Sciences. (2004). <http://hfcdhcp.org/briefs/brief6-tax-incentives/>.
- <sup>68</sup> Centers for Medicare & Medicaid Services. “Medicare Proposes Substantial Improvements to Paying for Care Coordination and Planning, Primary Care, and Mental Health in Doctor Payment Rule.” Press

release. (2016). <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-07-07.html>

<sup>69</sup> National Council on Disability. *The Current State of Health Care for People with Disabilities*. (2009). <http://www.ncd.gov/publications/2009/Sept302009>.

<sup>70</sup> Skopec, L. & S. K. Long, Urban Institute, Health Reform Monitoring Survey. “Poor Treatment by Health Care Providers and Staff is More Common among Vulnerable Populations.” (2016). <http://hrms.urban.org/briefs/poor-treatment-health-care-providers-vulnerable-populations.html>

<sup>71</sup> Lagu, T., L. I. Iezzoni & P. Lindenauer. “The Axes of Access—Improving Care for Patients with Disabilities.” *New England Journal of Medicine* 370(19):1847–1851. (2014).

<sup>72</sup> Institute of Medicine. *Crossing the Quality Chasm*. Washington, DC: National Academy Press. (2001).

<sup>73</sup> Administration for Community Living. “Section 2402(a) of the Affordable Care Act- Guidance for Implementing Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs.” (2014). <https://www.acl.gov/sites/default/files/news%202016-10/2402-a-Guidance.pdf>