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Giving Meaning to "Meaningful Access" in Medicaid Managed Care

Mary Crossley[1]

Introduction

"*HUGE Experiment Aims to Save on Care for Poorest, Sickest Patients*" read a headline on the Kaiser Health News website in December 2012.[2] The "experiment" to which the headline referred was not the clinical trial of an unproven drug on impoverished and illiterate patients in a developing country, but instead was the State of California's compulsory enrollment of nearly 240,000 people with disabilities and seniors into managed care plans as part of its Medi-Cal program.[3] The news story described how some Medi-Cal enrollees subject to the mandatory enrollment were facing disruptions of ongoing treatment relationships with their doctors and the resulting risks to their health.[4] California's purpose was to provide health care services for Medi-Cal beneficiaries that were better coordinated and integrated, while reining in ever-mounting Medi-Cal expenditures. The effort is aptly characterized as an "experiment" because it remains far from certain how and whether these dual goals are achievable.[5] And it is an experiment that other states will replicate in the coming decade.

Questions about whether and how to shift Medicaid recipients with disabilities out of the traditional fee-for-service setting and into managed care plans are not new.[6] Although Medicaid managed care enrollment overall

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1 Professor of Law, University of Pittsburgh School of Law. My thanks go to Leslie Pickering Francis and Lu-in Wang for their insightful comments on a draft of this article and to Jessica Ton for her valuable research assistance. This article grew from a presentation given at the Disability Law Section's panel at the AALS Annual Meeting in January 2013.

2 Mary Agnes Carey & Sarah Varney, *Huge Experiment Aims to Save on Care for Poorest, Sickest Patients*, Kaiser Health News (Dec. 5, 2012), http://www.kaiserhealthnews.org/stories/2012/december/06/medicare-medicaid-managed-care-experiment.aspx.

3 Bobbie Wunsch & Karen Linkins, Cal. HealthCare Found., A First Look: Mandatory Enrollment of Medi-Cal's Seniors and People with Disabilities into Managed Care 2 (2012), *available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/F/PDF%20FirstLookMandatoryEnrollmentSPD.pdf. "Medi-Cal" is the name of California's Medicaid program. *Id.*

4 Carey & Varney, *supra* note 2.

5 *Id.*

6 *See generally* Marsha Regenstein & Stephanie E. Anthony, Urban Inst., Econ. & Soc. Research Inst., Medicaid Managed Care for Persons with Disabilities (1998), *available at* http://www.urban.org/UploadedPDF/occa11.pdf.

has increased dramatically over the past two decades,[7] the group of Medicaid beneficiaries with the most complex and expensive health needs still receive their care predominately in fee-for-service settings.[8] State governments and policy analysts have long puzzled over how to shift populations characterized by medically complex problems and significant non-medical support needs into managed care settings in a way that both enhances (or at least maintains) their health and controls program spending.[9] But, for the most part, states' forays into this uncharted territory have been small in scale.[10]

Several reasons explain states' tentative pace. Central among them are states' concerns about their ability to contract with managed care organizations that have the capacity to meet the medical needs of low-income people with disabilities.[11] These concerns, in turn, prompt questions about the legal adequacy of the access and care that managed care plans will provide disabled Medicaid enrollees.[12]

Despite these concerns, the movement of people with disabilities into Medicaid managed care plans will likely accelerate over the next several years. Even as cost-containment pressures continue to mount, in 2014 many states will expand their Medicaid programs as part of health care reform, and more than half the states hope to take advantage of new demonstration projects permitting the integration of care and coverage for Medicaid recipients who also have Medicare coverage.[13] Both these steps will likely entail making managed care enrollment compulsory for more disabled Medicaid recipients. Given the high stakes for this group,[14] careful advance planning for shifting disabled Medicaid enrollees into managed care, close oversight, and appropriate responses to any problems that arise as implementation proceeds are critically important.

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7 *See* KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., MEDICAID AND MANAGED CARE: KEY DATA, TRENDS, AND ISSUES 1 (2010) [hereinafter MEDICAID AND MANAGED CARE 2010], *available at* http://www.lindsayresnick.com/Resource_Links/KFF_Medicaid.pdf.

8 KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., PEOPLE WITH DISABILITIES AND MEDICAID MANAGED CARE: KEY ISSUES TO CONSIDER 2 (2012) [hereinafter PEOPLE WITH DISABILITIES AND MEDICAID MANAGED CARE], *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8278.pdf.

9 *See, e.g.*, *id.* at 1.

10 *Id.* at 3 ("[M]anaged care has so far remained a relatively small phenomenon among Medicaid beneficiaries with disabilities.").

11 *Id.*; *see also* discussion *infra* Part I.

12 *See, e.g.*, Mary Crossley, *Medicaid Managed Care and Disability Discrimination Issues*, 65 TENN. L. REV. 419, 423 (1998) (examining "issues potentially raised under the ADA by states' decisions whether and how to include disabled Medicaid recipients in the massive shift towards Medicaid managed care"); *cf.* Mary R. Anderlik & Wendy J. Wilkinson, *The Americans with Disabilities Act and Managed Care*, 37 HOUS. L. REV. 1163, 1164 (2000) (discussing the adequacy of access and care of managed care under the ADA).

13 *See* discussion *infra* Part II.B.2.

14 *See* discussion *infra* Part I.

As states plan further expansion of Medicaid managed care, this Article examines the possibility that disability discrimination law might provide a mechanism for prodding states in the planning stage (before people with disabilities are compelled to enroll in managed care) to anticipate and plan for likely access issues, as well as for challenging any systemic access problems that arise as enrollment proceeds. Although the Supreme Court's 1985 decision in *Alexander v. Choate*[15] signaled a reluctance to use disability discrimination law to police the decisions of state Medicaid policy makers,[16] *Choate's* holding need not be an insurmountable barrier if compulsory enrollment in Medicaid managed care has an adverse disparate impact on people with disabilities. Today, state Medicaid officials typically are well aware of the access issues posed by shifting their disabled enrollees into managed care and, in the case of many disabled beneficiaries, are required to obtain approval from the federal Centers for Medicare and Medicaid Services (CMS) before compelling their enrollment.[17]

This Article argues that the process of obtaining CMS approval lays the foundation for a disparate impact claim under § 504 of the Rehabilitation Act[18] and Title II of the Americans with Disabilities Act[19] (ADA). More specifically, I will argue that access-related standards contained in states' applications to proceed with mandatory managed care enrollment—if those standards are not met—can support a claim that a state fails to provide disabled Medicaid enrollees with "meaningful access" to the state's Medicaid benefits. Such a claim should be cognizable, even under *Choate*. Thus, this Article provides a conceptual roadmap for disability advocates for framing such a claim, while also highlighting both the advantages of this approach and its potential shortcomings.

To that end, this Article will proceed as follows. Part I will describe why the stakes are particularly high for Medicaid beneficiaries with disabilities who are required to enroll in managed care and suggest that the greater potential peril they face as a result of mandatory enrollment may give rise to a disparate impact claim. Part II will explain briefly why the very concept of mandatory managed care for Medicaid beneficiaries with disabilities is unexpectedly complex. In light of that complexity, Part III will describe the challenges that Supreme Court precedent establishing a "meaningful access" standard for disparate impact claims poses for disability advocates advancing a claim based on mandatory managed care enrollment. Part III also will suggest an approach to meeting those challenges through reliance on states' need to seek federal approval for compelled enrollment of Medicaid beneficiaries with disabilities.

15 Alexander v. Choate, 469 U.S. 287 (1985).

16 *See* discussion *infra* Part III.B.

17 *See* discussion *infra* Part II.B.2.

18 Rehabilitation Act of 1973 § 504, 29 U.S.C. § 794 (2012).

19 Americans with Disabilities Act, Pub. L. No. 101-336, tit. 2, 104 Stat. 328 (codified at 42 U.S.C. §§ 12131-12165 (2012)).

Part IV will explore briefly some of the possible advantages to the suggested approach, as well as some of its weaknesses, followed by a conclusion.

I. High Stakes for People with Disabilities

The Medicaid program is enormously important for people with disabilities. Although many think of it as a health insurance program simply for poor people, Medicaid is a key source of insurance coverage for people with disabilities.[20] It fills important gaps for people whose disability (or employers' reaction to their disability) prevents them from working to the extent needed to qualify for employer-provided coverage, and its benefits extend to types of services that—while important to people with disabilities—private insurance does not typically fully cover.[21] As a result, the Medicaid-covered population has a higher prevalence of people with disabilities than does the population with private health insurance. In Fiscal Year 2011 Medicaid covered approximately 10.7 million people with disabilities.[22] This group represents only 15% of Medicaid beneficiaries, but their spending accounts for 42% of Medicaid's total.[23] Meanwhile, expenditures for nonelderly people with disabilities have grown more quickly than other segments of Medicaid costs.[24]

Because of Medicaid's importance to people with disabilities, proposed changes to how the program provides and pays for medical and other services are subjects of intense concern for those individuals and their advocates. And because people with disabilities are such a significant driver of Medicaid costs, it seems inevitable that the coming decade will see states continuing to push to control those costs, most likely through initiatives to enroll larger numbers

20 *See* Kaiser Comm'n on Medicaid and the Uninsured, The Henry J. Kaiser Family Found., Medicaid: A Primer 1 (2013) [hereinafter Medicaid: A Primer 2013], *available at* http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf.

21 Kaiser Comm'n on Medicaid and the Uninsured, The Henry J. Kaiser Family Found., Medicaid Eligibility and Enrollment for People with Disabilities Under the Affordable Care Act: The Impact of CMS's March 23, 2012 Final Regulations 3 (2012) [hereinafter Medicaid Eligibility], *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8390.pdf.

22 Elicia J. Herz, Cong. Research Serv., RL33202, Medicaid: A Primer 14 (2012), *available at* http://www.fas.org/sgp/crs/misc/RL33202.pdf. The precise number of people with disabilities who are enrolled in Medicaid is difficult to estimate. *See infra* Part II.A.

23 People with Disabilities and Medicaid Managed Care, *supra* note 8, at 2. This aggregate figure, however, fails to recognize that spending varies widely among disabled Medicaid beneficiaries, from those who receive long-term care in nursing homes, to those who live in the community and need less intensive services and supports. In Fiscal Year 2009, 60% of the $15,840 average per person Medicaid spending for disabled persons was for acute care and 40% was for long-term care. *See* Medicaid: A Primer 2013, *supra* note 20, at 27.

24 *See* Bruce C. Vladeck, *Where the Action Really Is: Medicaid and the Disabled*, Health Aff., Jan.-Feb. 2003, at 90, 90.

of disabled recipients in managed care.[25] These efforts represent a natural progression in Medicaid policy.

Over the past few decades, states have increasingly employed managed care techniques in efforts to control and rationalize spending for the majority of Medicaid enrollees comprising low-income children, their parents, and pregnant women,[26] and to pursue the improved outcomes predicted to flow from better access to and coordination of care. It is news to no one, however, that state Medicaid programs face ongoing budgetary pressures.[27] So the multiple motivations, cutting costs while improving oversight and coordination of care, and thus outcomes,[28] that already have prompted states to enroll most of their non-disabled Medicaid beneficiaries in managed care now increasingly present an imperative to similarly shift disabled beneficiaries who have largely remained in fee-for-service settings.[29]

Moving Medicaid recipients with disabilities into managed care, however, is not as straightforward as simply enrolling them in the managed care plans already serving Medicaid populations. Many of these plans are adapted to meet the medical needs of existing Medicaid managed care enrollees, namely children, their parents and caretakers, and pregnant women, and those needs—centered around primary and preventive care—differ significantly from the varied and complex needs of low-income people with disabilities.[30] Moreover, many plans now serving Medicaid recipients are "Medicaid only" plans (meaning that they do not participate in the commercial market for employer plans), and they may rely heavily on safety-net providers like community health centers to provide services to Medicaid recipients.[31] Plans hired to manage the care of disabled

25 *Cf.* John K. Iglehart, *Desperately Seeking Savings: States Shift More Medicaid Enrollees to Managed Care*, 30 HEALTH AFF. 1627, 1627, 1629 (2011) (describing the expansion of Medicaid managed care to the aged and disabled as "the most transformative change" states are pursuing in Medicaid and finding no "realistic alternatives to the managed care juggernaut that is about to play out nationwide").

26 *See* MEDICAID AND MANAGED CARE 2010, *supra* note 7, at 1.

27 KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., MEDICAID AND ITS ROLE IN STATE/FEDERAL BUDGETS & HEALTH REFORM 4 (2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2012/05/8139-03.pdf.

28 Achieving these goals has been elusive for American health policy makers. *Cf.* Theodore Marmor & Jonathan Oberlander, *From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy*, 27 J. GEN. INTERNAL MED. 1215, 1215 (2012) (describing Americans' unsuccessful "quest for the 'holy grail'—a reform that will decisively curtail spending while simultaneously improving quality of care").

29 States' use of managed care for people with disabilities has already begun. While less than 20% of states' spending on disabled recipients is for managed care payments on their behalf, a majority of states report that they mandate the managed care enrollment of some number of disabled beneficiaries. *See* PEOPLE WITH DISABILITIES AND MEDICAID MANAGED CARE, *supra* note 8, at 1-2.

30 *See id.* at 2-3, 6-7.

31 *See* KATHLEEN GIFFORD ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., A PROFILE OF MEDICAID MANAGED CARE PROGRAMS IN 2010: FINDINGS FROM A 50-STATE SURVEY 18, 26 (2011) [hereinafter PROFILE OF MEDICAID MAN-

Medicaid enrollees must be adapted to meet different needs, likely entailing participation by more specialists and academic medical centers.[32]

Moreover, the fact that a significant proportion of disabled Medicaid recipients also have Medicare coverage further complicates the challenge of shifting those enrollees from fee-for-service settings into managed care. These are part of a group referred to as "dual eligibles," which included 9.6 million seniors and younger people with significant disabilities in 2010.[33] Dual eligibles are among the poorest, sickest, and most expensive beneficiaries covered by either Medicaid or Medicare.[34] Their coverage is fragmented between the two public insurance programs, and as a result, decisions about their care are often uncoordinated.[35] While not all disabled Medicaid enrollees are dual eligibles and not all dual eligibles are disabled, these two groups overlap significantly.[36] Seeking to address this fragmentation and the resulting cost inefficiencies, a provision of the Affordable Care Act authorizes a new office within CMS, the Center for Medicare and Medicaid Innovation, with authority to approve demonstration projects entailing partnerships between state Medicaid programs and CMS (which has sole responsibility for administering Medicare) designed to integrate and align the care of and financing for dual eligibles.[37] The prospect of these partnerships may both accelerate and influence how some states go

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AGED CARE], *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8220.pdf.

32 *See* MEDICAID AND MANAGED CARE 2010, *supra* note 7, at 3, 4.

33 *See* KATHERINE YOUNG ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., MEDICAID'S ROLE FOR DUAL ELIGIBLE BENEFICIARIES 1 (2013) [hereinafter MEDICAID'S ROLE], *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/08/7846-04-medicaids-role-for-dual-eligible-beneficiaries.pdf.

34 *Id.* at 2.

35 For a description of how coverage and funding are fragmented for dual eligibles and how that fragmentation can negatively affect both the care provided and the ability to control costs, see generally Patricia Neuman et al., *Dx for a Careful Approach to Moving Dual-Eligible Beneficiaries into Managed Care Plans*, 31 HEALTH AFF. 1186, 1186 (2012). *See also* Marsha R. Gold et al., *There Is Little Experience and Limited Data to Support Policy Making on Integrated Care for Dual Eligibles*, 31 HEALTH AFF. 1176, 1176 (2012) ("Each [program] is structured around specific types of services, and each includes its own administrative and service limitations and does not necessarily address the composite needs for integrated coverage for people served by both programs."). One reason for the lack of coordination is that, while Medicare is a purely federal health insurance program, Medicaid is a joint federal-state program that is administered at the state level. *See id.* While state Medicaid programs are subject to numerous constraints in the federal Medicaid statute and regulations, states also have a large degree of discretion to adapt their programs to the particular needs of their state. Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs. (CMCS), to State Medicaid Dir. (Mar. 18, 2013), *available at* http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-003-02.pdf.

36 Sixty percent of non-elderly Medicaid enrollees with disabilities are not eligible for Medicare. MEDICAID'S ROLE, *supra* note 33, at 4.

37 42 U.S.C. § 1315a(a)(1) (2012); *see generally* KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., EXPLAINING THE STATE INTEGRATED CARE AND FINANCIAL ALIGNMENT DEMONSTRATIONS FOR DUAL ELIGIBLE BENEFICIARIES (2012), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8368.pdf.

about increasing their reliance on managed care to provide services for their disabled Medicaid enrollees.

Even beyond these organizational complexities, the anticipated transition to managed care is fraught with both promise and peril for disabled Medicaid recipients. The very characteristics that make managed care organizations appealing to state Medicaid planners—defined provider networks, comprehensive coverage of services, and capitated pricing—have also produced conflicting expectations about how mandatory enrollment will affect access to care for people with disabilities.[38] On the one hand, managed care seeks to improve the coordination of care and encourage the use of preventive services, which in theory should improve satisfaction and outcomes for people with disabilities *and* reduce the cost of care.[39] Moreover, if managed care can effectively integrate the preventive care, acute care, and long–term services and supports (LTSS) that people with disabilities receive, they may be better able to avoid institutionalization and remain in the community.

On the other hand, managed care's use of capitated payments (combined with imperfect risk adjustment for people with disabilities) and utilization management may lead to "cherry picking"[40] and enrollee under–service.[41] In addition, because most managed care plans have limited experience serving people with disabilities, they may lack adequate networks of specialist providers and be unprepared to serve enrollees whose medical needs are often interwoven with needs for durable medical equipment, ancillary supports, and long–term care.[42] As a result, even if a managed care plan's contract with the state requires it to provide a full range of Medicaid–covered services, it may not have contracts with a mix of providers capable of fully meeting disabled enrollees' needs.

The evidentiary basis for judging whether these concerns are justified is scant, largely because relatively few disabled Medicaid recipients have been compelled to enroll in managed care until recently. The limited research that has been published contains mixed findings regarding managed care enrollment's effect on access to care.[43] Despite the limited research to date, policy analysts and

38 Marguerite E. Burns, *Medicaid Managed Care and Health Care Access for Adult Beneficiaries with Disabilities*, 44 HEALTH SERVICES RES. 1521, 1523 (2009).

39 *See* Deanna Okrent, *Can It Succeed? States to Roll out More Medicaid Managed Care*, HEALTH PROGRESS 23 Nov.—Dec. 2012 *available at* http://www.chausa.org/docs/default–source/health–progress/426c77d5d70d442d8fe366b92db827341–pdf.

40 *See* Nina Bernstein, *Advocates Say Managed–Care Plans Shun the Most Disabled Medicaid Users*, N.Y. TIMES, May 1, 2013, at A20 (describing examples reported by advocates for the disabled in New York).

41 *See* Burns, *supra* note 38, at 1523; Iglehart, *supra* note 25, at 1628 (noting that capitated arrangements provide "inherent incentives to underserve patients or deny them access to needed care").

42 *See* PEOPLE WITH DISABILITIES AND MEDICAID MANAGED CARE, *supra* note 8, at 2.

43 One literature review of the effects of managed care for children with special health care needs found some evidence of increased access for those children when they were enrolled in a Medicaid or State Children's Health Insurance Program managed care plan, as compared to the

advocacy groups have explored and robustly discussed both the promise and the peril associated with shifting people with disabilities into Medicaid managed care.[44] The resulting policy briefs and white papers catalog steps that Medicaid planners can take to maximize the beneficial coordination and quality of care for disabled enrollees while avoiding barriers to access.[45] For example, plans are encouraged to recruit physicians and practices that are committed to serving patients with both mental and physical limitations and to provide cultural competency training for physicians and staff to enhance their understanding of and sensitivity to the special needs of persons with disabilities.[46]

While experts can identify likely pitfalls and suggest potential fixes, no one can predict with certainty exactly what will happen once the transition occurs on a large scale. Hence the "*Huge Experiment*" headline from California.[47] What seems certain, however, is that when it comes to mandatory enrollment in Medicaid managed care, the stakes are higher for people with disabilities than for the rest of the covered population.[48] If this "experiment" is a success,

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traditional fee-for-service Medicaid program. Lynne C. Huffman et al., *Impact of Managed Care on Publicly Insured Children with Special Health Care Needs*, 10 ACAD. PEDIATRICS 48, 48, 50, 53 (2010). By contrast, a study of adults with disabilities found that, relative to fee-for-service enrollees, Medicaid recipients enrolled in managed care plans were 32% more likely to report a problem getting to see a specialist and 10.2% less likely to report having received a flu shot in the past year. Burns, *supra* note 38, at 1531-32. For a summary of key research on Medicaid managed care and people with disabilities see PEOPLE WITH DISABILITIES AND MEDICAID MANAGED CARE, *supra* note 8, at 16-17 app.

44 *See, e.g.*, NAT'L COUNCIL ON DISABILITY, ANALYSIS AND RECOMMENDATIONS FOR THE IMPLEMENTATION OF MANAGED CARE IN MEDICAID AND MEDICARE PROGRAMS FOR PEOPLE WITH DISABILITIES 1-5 (2012) [hereinafter NCD ANALYSIS AND RECOMMENDATIONS], *available at* http://www.ncd.gov/rawmedia_repository/de64d45c_3ab8_48da_9fcc_12acca398c05?document.pdf (indicating the important implications and adverse effects in regard to changes in the system); NAT'L COUNCIL ON DISABILITY, MEDICAID MANAGED CARE FOR PEOPLE WITH DISABILITIES: POLICY AND IMPLEMENTATION CONSIDERATIONS FOR STATE AND FEDERAL POLICYMAKERS 1 (2013) [hereinafter NCD POLICY AND IMPLEMENTATION CONSIDERATIONS], *available at* http://www.ncd.gov/rawmedia_repository/20ca8222_42d6_45a5_9e85_6bd57788d726?document.pdf (setting forth twenty-two principles to "guide the design and implementation of managed care for people with disabilities"); *see generally* PEOPLE WITH DISABILITIES AND MEDICAID MANAGED CARE, *supra* note 8 (recognizing both the pros and the cons of such a system); *cf.* DEBRA J. LIPSON ET AL., AARP PUB. POLICY INST., KEEPING WATCH: BUILDING STATE CAPACITY TO OVERSEE MEDICAID MANAGED LONG-TERM SERVICES AND SUPPORTS 4 (2012), *available at* http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/keeping-watch-building-state-capacity-to-oversee-medicaid-managed-ltss-AARP-ppi-health.pdf (providing further insight into program implementation issues, as well as benefits).

45 *See* PEOPLE WITH DISABILITIES AND MEDICAID MANAGED CARE, *supra* note 8, at 7.

46 *See id.*

47 *See* Carey & Varney, *supra* note 2 and accompanying text; Iglehart, *supra* note 25, at 1627 (calling the likely impact of Medicaid managed care on people with disabilities and the elderly "a major unknown").

48 *See* PEOPLE WITH DISABILITIES AND MEDICAID MANAGED CARE, *supra* note 8, at i (noting that "both the potential risks and gains [of Medicaid managed care] may be greatest" for people with disabilities).

then disabled enrollees stand to reap great benefits in terms of the integration and coordination of the varied types of services they need. But if it fails, their greater medical and support needs make them especially vulnerable to suffering from a lack of access and disruption in their care. In short, a real risk exists that mandatory enrollment in Medicaid managed care could cause disproportionate harm to disabled enrollees.

II. Complexity in Framing the Question

In light of this risk, this Article considers a basic question: Would § 504 of the Rehabilitation Act or Title II of the ADA[49] provide a remedy for Medicaid recipients with disabilities if their mandatory enrollment in managed care produced an adverse disparate impact on them?[50] As discussed below, advocates for people with disabilities should have a strong argument that the answer to this question is "yes." But, for several reasons, the very terms of the question are surprisingly complex. In particular, two aspects of this complexity flow from the intricate nature of Medicaid eligibility, coverage, and administration.[51] First, defining "Medicaid recipients with disabilities" as a distinct group is tricky.[52] Second, understanding when and how states can compel disabled Medicaid

49 State Medicaid agencies are simultaneously recipients of federal financial assistance, which subjects them to the coverage of § 504 of the Rehabilitation Act of 1973 and public entities subject to the terms of Title II of the ADA. *See* Loye v. County of Dakota, 625 F.3d 494, 496 (8th Cir. 2010). Although the "meaningful access" standard originated in *Alexander v. Choate*, a case decided under § 504, it applies as well to claims brought under Title II. *See id.* (construing Title II to incorporate the standard). Because the extent to which Title II abrogates state sovereign immunity remains a contested question, however, disability advocates alleging a state Medicaid program's failure to provide meaningful access may choose to state claims under both statutes. *See* United States v. Georgia, 546 U.S. 151, 159 (2006) (holding that Title II abrogates state sovereign immunity to the extent that it permits private damages action against states for conduct that actually violates the Fourteenth Amendment); Betsy Ginsberg, *Out with the New, In with the Old: The Importance of Section 504 of the Rehabilitation Act to Prisoners with Disabilities*, 36 Fordham Urb. L.J. 713, 729–35 (2009) (describing the uncertainty regarding sovereign immunity and Title II); Ani B. Satz, *Fragmented Lives: Disability Discrimination and the Role of "Environment Framing,"* 68 Wash. & Lee L. Rev. 187, 224 (2011) ("[T]he boundaries of [ADA Title II's] abrogation are unclear under the U.S. Supreme Court jurisprudence."). In fact, Ginsberg suggests that in some instances disability advocates consider bringing claims based on § 504 alone. *See* Ginsberg, *supra*, at 744–45. Because Congress's Spending Clause authority is an independent basis for enacting § 504, states are generally held to waive their Eleventh Amendment defense by their ongoing acceptance of federal funds. *Id.* at 734.

50 *See* Elizabeth Pendo, *Disability, Equipment Barriers, and Women's Health: Using the ADA to Provide Meaningful Access*, 2 St. Louis U. J. Health L. & Pol'y 15, 49–53 (2008) (noting disparate treatment claims may also be available when managed care providers do not have fully accessible offices or equipment).

51 *Cf.* Sara Rosenbaum et al., Olmstead v. L.C.: *Implications for Medicaid and Other Publicly Funded Health Services*, 12 Health Matrix 93, 124 (2002) [hereinafter Rosenbaum et al., *Olmstead v. L.C.*] ("Medicaid is . . . one of the most complex pieces of social welfare legislation ever enacted."). Rosenbaum's article provides a concise and helpful description of the Medicaid program. *Id.* at 124–31.

52 *Id.* at 126–27 (noting the different ways a state can define "disability").

recipients to enroll in managed care requires at least a basic grasp of the types of managed care that Medicaid programs employ and the waiver process that states typically must use to compel this population's enrollment in managed care. This Part briefly elucidates these complicating matters, before the Article proceeds in Part IV to address the question head on.

A. Who Are "Medicaid Recipients with Disabilities"?

Historically, eligibility for Medicaid has been based on a person having a low income and falling into a statutorily defined eligibility category.[53] These categories provide pathways to Medicaid eligibility, and while one of these pathways is explicitly disability–focused, people with disabilities may become eligible for Medicaid via other pathways as well.

The most disability–congruent category comprises nonelderly people who are eligible for Medicaid because they qualify for Supplemental Security Income (SSI) payments from the federal government by having a low income, limited assets, and a significant disability that prevents them from engaging in substantial gainful employment.[54] This group is itself quite heterogeneous, including, for example, people with developmental disabilities, people with persistent mental illnesses, people living with AIDS, disabled children, and physically disabled but cognitively intact adults.[55]

Even Medicaid recipients who have achieved coverage via other pathways may have conditions that qualify as disabilities, enabling them to assert rights under § 504 and the ADA. In short, poor adults, children, and elderly people may have impairments that significantly limit major life activities, even if not sufficiently disabling to qualify for SSI payments.[56] For example, a person eligible for SSI because she is elderly and poor may also become disabled as

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53 Though the number of eligibility categories has grown over time as Congress has expanded Medicaid to cover more poor people, the core groups of low–income people eligible for Medicaid coverage (expressed in the simplest terms) are children and their adult parents or caretakers, pregnant women, elderly people, and people with disabilities. *See* HERZ, *supra* note 22, at 1. The broad group thus excluded historically from Medicaid coverage are nondisabled, childless adults under the age of 65. *Id.*

54 *See* MEDICAID ELIGIBILITY, *supra* note 21, at 4–5.

55 *See* Vladeck, *supra* note 24, at 91.

56 *See* MEDICAID ELIGIBILITY, *supra* note 21, at 5–6. Disability discrimination law's definition of disability simply requires that an impairment substantially limit a major life activity (or that a person have a history of or be regarded as having such an impairment). 42 U.S.C. § 12102(1) (2012). The ADA Amendments Act in 2008 contained specific provisions rejecting a narrow judicial construction of the term "disability," which made clear that Congress intended a broad interpretation of the term. *See* Elizabeth F. Emens, ***Disabling Attitudes: U.S. Disability Law and the ADA Amendments Act***, 60 AM. J. COMP. L. 205, 206 (2012) (footnotes omitted) ("For nearly two decades, the courts narrowed the scope of the ADA's mandate by, most obviously, interpreting 'disability' under the ADA in a restrictive manner. In 2008, Congress passed the ADA Amendments Act (ADAAA), which attempts to restore a broader vision of the original ADA by, in particular, expanding the statutory definition of disability.").

she ages. Similarly, a child, pregnant woman, or adult caretaker of a child may experience an impairment that, while it does not qualify her for SSI, places her within the ambit of disability discrimination law's protection.

These individuals might be thought of as "incidentally" disabled with respect to Medicaid eligibility. For them, disability is not the pathway to Medicaid eligibility, but they are protected against disability discrimination. This group will doubtless grow in size beginning in 2014, when states expand their Medicaid programs pursuant to the Affordable Care Act to cover nonelderly adults with incomes at or below 133% of the federal poverty level.[57] These beneficiaries are expected to include many previously ineligible single adults, and many in this group are likely to have mental health conditions or other serious medical needs, placing them within anti-discrimination law's definition of an individual with a disability.[58]

This distinction, between Medicaid recipients whose disability provides their pathway to SSI, and thus Medicaid eligibility, and recipients who qualify for Medicaid for other reasons but who also happen to have a disability, may prove analytically important for considering a potential disability discrimination remedy for ill effects that may flow from mandatory managed care enrollment. Advocates should be aware that discussions in popular, policy, and academic writing that refer to enrolling "disabled" Medicaid beneficiaries in managed care most often use the term as shorthand for disabled SSI recipients—a subset of all Medicaid recipients who are disabled for purposes of disability discrimination law. In addition, these disabled SSI recipients are the group whose mandatory enrollment in managed care has been fairly limited until recently, and whose mandatory enrollment requires a waiver from CMS, as discussed below.[59] In short, most discussions of people with disabilities in Medicaid do not include everyone who can claim the protections of disability discrimination law. But, as will become clear below, disabled persons who obtain their Medicaid coverage by virtue of receiving SSI may be best positioned to advance a disparate impact claim.

B. *Compelling Enrollment in Medicaid Managed Care*

Just as the phrase "disabled Medicaid recipients" may signify multiple meanings, a statement that states may compel those recipients to enroll in managed care requires some unpacking. Both the "managed care" that state Medicaid programs employ and states' ability to mandate enrollment in managed care present multi-layered concepts.

57 *See* HERZ, *supra* note 22, at 2–3.

58 *See* Judith Solomon, *Health Reform Expands Medicaid Coverage for People with Disabilities*, CENTER ON BUDGET AND POL'Y PRIORITIES 1 (July 29, 2010), http://www.cbpp.org/files/7-29-10health.pdf ("A substantial number of the people who will gain Medicaid coverage under health reform have disabilities or chronic health care conditions.").

59 *See generally infra* Part II.B.2 (discussing compelled enrollment in managed care).

1. Medicaid Managed Care.—The label "managed care" may apply to a wide variety of programs in which state Medicaid programs have enrolled beneficiaries over the past two decades. Pursuant to federal law, states participating in Medicaid must cover a wide range of benefits, and many states provide some, but not all, of those benefits on a managed care basis.[60] Most obviously, many states have enrolled some of their Medicaid beneficiaries in managed care plans that, like the managed care plans employers provide, cover a wide range of primary and acute medical care and preventive services.[61] A significant number of states have also begun experimenting with providing long-term services and supports (LTSS), such as nursing home care and in-home supportive services, on a managed basis.[62] In addition, some states that contract with managed care plans have created "carve-outs," in which discrete types of benefits (for example, pharmacy services, dental services, or behavioral health services) are carved out of the coverage that managed care plans provide.[63] These carved out services may be provided either through a separate limited benefit plan or through fee-for-service providers.[64] Thus, wide variation exists in the types of "care" that state Medicaid programs seek to manage, and this diversity will likely persist as states apply managed care approaches to more disabled Medicaid recipients. This Article focuses on states' enrollment of disabled recipients in managed medical care plans, but its analysis is largely applicable to the state's management of other benefits.[65]

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60 *See* HERZ, *supra* note 22, at 5-6 ("[F]ederal rules require states with Medicaid programs to cover certain benefits under the traditional Medicaid program."); KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., MEDICAID MANAGED CARE: KEY DATA, TRENDS, AND ISSUES 1 (2012), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8046-02.pdf ("Two-thirds of Medicaid enrollees now receive most or all of their benefits in managed care . . . .").

61 *See* MEDICAID AND MANAGED CARE 2010, *supra* note 7, at 2-3. Most of these Medicaid managed care options involve risk-based contracting with a managed care organization (MCO), where the state pays the MCO a fixed price for each beneficiary and the MCO assumes the risk of providing all covered services. *See id.* at 2. Some states, however, have employed a form of managed care known as primary care case management (PCCM). *See id.* In PCCM, the program pays a primary care provider a case management fee to manage and coordinate the care provided to Medicaid beneficiaries, reimbursing the physician for services rendered that are beyond basic care on a fee-for-service basis. *See id.*

62 *See* LIPSON ET AL., *supra* note 44, at 4, 6-7 (noting that in 2012 "as many as 20 states [were] expanding or plan[ning] to introduce risk-based managed care programs for Medicaid beneficiaries needing LTSS").

63 *See* PROFILE OF MEDICAID MANAGED CARE, *supra* note 31, at 13, 23-24.

64 *See generally* EMBRY M. HOWELL ET AL., URBAN INST., MEDICAID AND CHIP RISK-BASED MANAGED CARE IN 20 STATES 19-23 (2012), *available at* http://aspe.hhs.gov/health/reports/2012/riskbasedmanagedcare/rpt.pdf (discussing the various ways that states carve out services).

65 The analysis would not apply, however, to states' management of LTSS. LTSS recipients, who need assistance with activities of daily living, are by definition, disabled. If all participants in a program have disabilities, the program's impact on disabled participants cannot compare to its impact on non-disabled participants and thus, a disparate impact claim is unavailable.

2. *Compelling Enrollment in Managed Care.*—Although a number of states permit disabled Medicaid beneficiaries to enroll voluntarily in managed care plans designed for the general Medicaid population, states have been more hesitant to *require* that disabled beneficiaries enroll in managed care.[66] As a matter of disability discrimination law, compelling people with disabilities to enroll in a managed care plan raises concerns not applicable to optional enrollment.[67] Moreover, federal approval is often required for states to compel disabled beneficiaries to enroll in managed care plans.[68] The federal Medicaid statute sets out a number of requirements for state plans, including one that allows Medicaid enrollees to enjoy freedom of choice with respect to medical providers.[69] As a result, states seeking to limit that freedom have historically needed to obtain a waiver of the statutory requirement from CMS.[70]

The types and purposes of Medicaid waivers available to states have expanded significantly over time, and a thorough description of waiver programs and processes lies well beyond the scope of this Article. Several points regarding waivers, however, are particularly relevant to this Article's analysis.

First, the trend over the past few decades has been for Congress to grant states increasing latitude in tailoring their Medicaid programs to meet their particular needs, and this trend has resulted in states' requesting and implementing widely ranging waiver programs, with varying statutory bases and purposes.[71] The ensuing multiplicity of waiver programs makes it difficult

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66 *See* Sara Rosenbaum et al., Managed Care and Medi-Cal Beneficiaries with Disabilities: Assessing Current State Practice in a Changing Federal Policy Environment 3, 37 (2006), *available at* http://www.calendow.org/uploadedFiles/managed_care_medi-cal_beneficiaries.pdf. In 2006, the authors of a report commissioned by the California Endowment "were struck by the very limited extent of state experience with compulsory managed care for persons with disabilities, a fact that [they] attribute[d] to the complexity of implementing complex systems of care for persons who experience both extensive medical and health care needs and very low income." *Id.* at 3.

67 *See* Crossley, *supra* note 12, at 440 (noting that a state that makes managed care enrollment optional for SSI recipients "appears to be in the strongest position legally . . . [because it] allows each individual to choose the program he or she deems most effective in providing for specific health needs").

68 *See generally* Cynthia Shirk, Nat'l Health Policy Forum, The Basics: Medicaid and SCHIP Waivers 1, 4 (2008) [hereinafter Shirk, The Basics], *available at* http://www.nhpf.org/library/the-basics/Basics_MedicaidSCHIP.Waivers_07-30-08.pdf (discussing federal guidelines for Medicaid and SCHIP and program waivers).

69 *See id.* at 3.

70 *See id.*

71 *See id.* at 2–4. The statutory provisions typically invoked by states seeking to enroll Medicaid recipients in managed care on a mandatory basis include the following:

- Section 1915(b) waivers, by which CMS waives the Medicaid statute's "freedom of choice" and "statewideness" requirements for state programs. 42 U.S.C. § 1396n(b) (2012).
- Section 1115 waivers, by which CMS permits states to pursue demonstration projects experimenting with different approaches to achieving Medicaid's purpose. 42 U.S.C. § 1315(a), (e) (2012).

to talk about "the" Medicaid program broadly, or even "the" Medicaid program of a particular state.[72] Waiver programs may focus on how a particular type of covered service is provided or paid for, or may be limited to a particular population or geographic area.[73]

As part of this trend, Congress has made it easier for states to require Medicaid beneficiaries to enroll in managed care plans.[74] Before 1997, if a state wished to compel any beneficiaries' enrollment in managed care, it had to obtain a waiver from CMS.[75] In the 1997 Balanced Budget Act, however, Congress facilitated states' pursuit of Medicaid managed care by dispensing with the waiver requirement so long as the managed care plans used by the state met certain standards relating to plan quality, solvency, and beneficiary protections.[76]

Even with this easing, Congress retained limitations on compulsory managed care enrollment for some Medicaid populations deemed particularly vulnerable.[77] Specifically, waivers were still required for the mandatory enrollment of children with special needs and dual eligibles.[78] These groups overlap largely, if not entirely, with disabled Medicaid recipients.[79] As a result, states still have to seek CMS approval of a waiver in order to require many, but not all, disabled Medicaid recipients to enroll in managed care plans.[80]

- Section 1932 programs, by which states can amend their Medicaid plans to require the enrollment of many beneficiaries in managed care without having to obtain a waiver; this authority does not extend to enrollment of children with special needs, dual eligibles, and Native Americans. 42 U.S.C. § 1396u–2(a)(1)–(2) (2012).

For a discussion of these statutory provisions, see Mark H. Gallant, *Medicaid Managed Care: Statutory Standards, Provider Network Access and Coverage Obligations, and Hot Button Contract Issues*, AM. HEALTH LAWYERS ASSOC. 2–7, http://www.healthlawyers.org/events/programs/materials/documents/mm10/gallant.pdf (last modified Mar. 16, 2010, 3:04 PM).

72 As of December 2013, the federal government's Medicaid web page lists 452 different current waiver programs. *See* MEDICAID.GOV, *Waivers*, http://www.medicaid.gov/Medicaid–CHIP–Program–Information/By–Topics/Waivers/Waivers.html (last visited Jan. 6, 2014) (filtering by "current"). Many states have multiple waiver programs, many of which have nothing to do with managed care. *Id.* For example, Nebraska has eight separate waiver programs. *Id.*

73 *See generally id.* (noting the various types of waiver program implemented by each state). For example, Montana has a Children's Autism Waiver; New Jersey has a waiver to expand coverage to childless adults; and Alabama has a waiver to provide home and community–based services to persons with mental retardation. *Id.*

74 *See generally* SHIRK, THE BASICS, *supra* note 68, at 1–3 (discussing the various ways in which states can compel enrollment).

75 *See id.* at 3.

76 *See* MEDICAID AND MANAGED CARE 2010, *supra* note 7, at 2.

77 *See* Iglehart, *supra* note 25, at 1628.

78 *Id.*

79 Waivers are also still required for the mandatory enrollment of Native Americans covered by Medicaid. 42 U.S.C. § 1396u–2(a)(1) (2012). The category, "children with special needs," effectively includes most children with disabilities. *Id.* § 1396u–2(a)(2).

80 *See id.*

Most recently, in the Affordable Care Act, Congress authorized new demonstration projects entailing state partnerships with CMS to experiment with coordinating and integrating Medicaid and Medicare funding and services for dual eligibles.[81] The goal is twofold: provide better care to beneficiaries and increase savings to both Medicaid and Medicare. As of spring 2012, twenty-six states had submitted proposals for demonstrations to CMS, and by spring 2013, CMS has entered into a Memoranda of Understanding with six states to move forward with experimental programs.[82] These programs will use managed care for dual eligibles and thus, by extension, significant proportions of disabled Medicaid beneficiaries in the participating states.[83]

Ultimately, although Congress has repeatedly signaled its general support for states' efforts to move Medicaid recipients into managed care, in most instances when states seek to require the enrollment of disabled recipients, approval from CMS is still needed to accomplish that objective.[84] And, as described more fully below, in order to maximize the likelihood of CMS approval, states' waiver applications typically describe how they will ensure that disabled Medicaid beneficiaries required to enroll in managed care will have adequate access to covered services and providers.

III. Using the Waiver Process To Breathe Life into a Disparate Impact Claim

A. *The Challenge of Framing the Disability Discrimination Claim*

This need to apply to CMS for approval is key to this Article's thesis. In essence, a state program that requires disabled Medicaid recipients to enroll in managed care, but does not take the steps it has committed to through the CMS approval process to ensure that recipients have access to services and providers, may likely have an adverse disparate impact on people with disabilities. But, successfully pursuing such a disparate impact discrimination claim will require advocates to distinguish *Alexander v. Choate*, a Supreme Court decision rejecting the availability of disparate impact claims against a state Medicaid program as long as the state provides disabled recipients with "meaningful access" to its Medicaid benefits.[85] This Article argues that a state's undertakings regarding access-ensuring measures, made in the context of obtaining a waiver, provide a measure of "meaningful access" that should be enforceable via a disability

81 *See supra* note 37 and accompanying text.

82 *See* Neuman et al., *supra* note 35, at 1188.

83 *Id.* In its Financial Alignment Initiative, announced in 2011, CMS presented states with two possible models for the demonstration projects. *Id.* One is a capitated model that will enroll dual eligibles in managed care plans that contract to provide the full range of Medicaid and Medicare services. *Id.* The other model envisions a managed fee-for-service approach. *Id.*

84 *See* Shirk, The Basics, *supra* note 68, at 2-4; *supra* text accompanying notes 70-71, 75, 78.

85 Alexander v. Choate, 469 U.S. 287, 301, 303, 307-09 (1985).

discrimination claim. The next part of this Article describes and assesses the "meaningful access" limitation articulated in *Choate*, before explaining more fully how the argument might be used in a particular case.

To start, advocates should note that a disparate impact claim is probably the only disability discrimination claim available to disabled Medicaid beneficiaries who assert they are harmed by being required to enroll in managed care.[86] By requiring them to enroll in managed care, states are increasingly treating people with disabilities *the same as* their non-disabled Medicaid peers; thus, there is no apparent basis for alleging different treatment. Similarly, to the extent that non-disabled Medicaid beneficiaries experience access problems and other ill effects from mandatory enrollment in managed care, any claim of a *disparate* impact on people with disabilities dissipates. In other words, if experience proves that mandating Medicaid managed care is equally disastrous for all enrollees—disabled or not—then the policy (whatever its other failings) has no discriminatory impact. Only when advocates can show that the state policy compelling managed care enrollment has a greater adverse effect on people with disabilities is a disparate impact claim potentially viable.

B. Alexander v. Choate

Articulating how a state Medicaid policy produces an actionable discriminatory impact on people with disabilities presents a real challenge, especially in light of *Alexander v. Choate*.[87] In that case, disabled Medicaid recipients sued Tennessee, alleging that the State's Medicaid plan disparately affected people with disabilities, and thus violated § 504 of the Rehabilitation Act, by limiting its coverage of inpatient hospital care to fourteen days per year.[88] Supporting their claim, plaintiffs presented statistical evidence that a significantly higher percentage of disabled Medicaid beneficiaries needed more than fourteen days of hospital care, as compared to non-disabled beneficiaries.[89]

86 The caveat regarding the possibility of a disparate treatment claim—when managed care providers do not have fully accessible offices or equipment—applies here as well. *See* Pendo, *supra* note 50. In contrast to claims flowing from mandatory managed care enrollment, Medicaid changes and cutbacks that threaten the ability of disabled beneficiaries to live outside of institutions have prompted lawsuits based on *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999). *See, e.g.*, Pashby v. Delia, 709 F.3d 307, 313 (4th Cir. 2013) (upholding preliminary injunction to disabled Medicaid recipients who alleged that North Carolina's tightening of eligibility standards for Medicaid coverage for in-home personal care services placed them at risk of institutionalization); M.R. v. Dreyfus, 697 F.3d 706, 706 (9th Cir. 2012) (granting preliminary injunction to disabled Medicaid beneficiaries who alleged that a decrease in Washington's Medicaid coverage of in-home personal care services would violate the ADA). *Olmstead* stands for the proposition that a state's unnecessary institutionalization of a person with a disability, who could effectively receive community-based treatment, violates the ADA. *See* Olmstead v. L.C. *ex rel.* Zimring, 527 U.S. 581, 582 (1999).

87 *Choate*, 469 U.S. 287.

88 *Id.* at 289–90.

89 *Id.* at 289.

In considering this argument, the Supreme Court accepted the premise that Congress did not intend to limit § 504 to addressing intentional discrimination, but found "troubling" the contention that it should interpret the statute to reach all actions disparately affecting people with disabilities.[90] Writing for a unanimous Court, Justice Marshall questioned whether Congress could have intended § 504 to reach all instances of disparate impact, a conclusion he reasoned would require all recipients of federal financial assistance to assess the potential effect of every policy choice on disabled people.[91] In light of these broad implications, the Court emphasized the need for a balanced approach to interpreting § 504's scope: "Any interpretation of § 504 must . . . be responsive to two powerful but countervailing considerations—the need to give effect to the statutory objectives and the desire to keep § 504 within manageable bounds."[92]

Thus, in the same breath, the Court rejected the idea that *all* showings of disparate impact presented prima facie cases under § 504, but assumed that the statute reached *some* actions producing an unjustifiable disparate impact on people with disabilities.[93] Turning to its decision in *Southeastern Community College v. Davis*[94] for guidance in determining *which* disparate impacts give rise to cognizable § 504 claims, the Court concluded that § 504 does not require a federal grantee to fundamentally alter a program in order to avoid *all* differential effects on people with disabilities.[95] The statute, however, does require a state (as a federal grantee) to provide people with disabilities with "meaningful access" to whatever benefit the state offers through Medicaid, and the state may sometimes have to make reasonable modifications to its programs to assure meaningful access.[96]

Applying this distinction to Tennessee's limitation, the Court reasoned that the State had not deprived disabled Medicaid recipients of meaningful access to the benefit at issue—fourteen days of inpatient coverage: "The reduction in inpatient coverage will leave both handicapped and nonhandicapped Medicaid users with identical and effective hospital services fully available for their use . . . ."[97] It rejected any contention that the Medicaid program's benefit was "adequate health care" and emphasized that federal law gives states substantial discretion to determine what benefits their Medicaid program will cover.[98] According to the Court, § 504 does not require a state to redefine the Medicaid benefits it offers to assure that disabled Medicaid beneficiaries—despite their

90 *Id.* at 294–98.

91 *Id.* at 297–98.

92 *Id.* at 299.

93 *Id.*

94 Southeastern Community College v. Davis, 442 U.S. 397 (1979).

95 *Choate*, 469 U.S. at 299–300.

96 *Id.* at 301.

97 *Id.* at 302.

98 *Id.* at 302–03.

greater medical needs—achieve the same health outcomes as non-disabled Medicaid beneficiaries.[99] Because it found that the inpatient coverage benefit under Tennessee's program was "equally accessible to both handicapped and nonhandicapped persons," the Court concluded that the plaintiffs had not stated a cognizable § 504 claim.[100]

C. *Applying* Choate *To Mandatory Medicaid Managed Care for Medicaid Recipients with Disabilities*

Even as *Choate* assumed that § 504 reaches some instances of discriminatory impact, the Court employed a "meaningful access" standard to reject unanimously a claim where plaintiffs presented evidence of disparate impact on disabled Medicaid recipients.[101] *Choate*'s rejection of a disparate impact challenge to Medicaid cost-cutting measures thus erects a significant barrier for disability advocates seeking to use disability discrimination law to challenge other cost-cutting measures, like the mandatory enrollment of disabled Medicaid recipients in managed care plans.[102]

Professors Leslie Francis and Anita Silvers, however, assert that the potential avenues for overcoming or avoiding this barrier have been insufficiently explored and that advocates should build on *Choate*'s recognition that § 504 extends to some state program actions that discriminate in their impact.[103] One way of limiting *Choate*'s precedential clout is to read it as a fact-specific ruling in a case where plaintiffs had failed to provide strong evidence of patients with disabilities who had actually suffered harm as a result of Tennessee's limit on inpatient coverage.[104] Under this reading, a lawsuit where disabled plaintiffs muster stronger evidence of differential harm might succeed in proving they have been deprived of meaningful access to a specific benefit like inpatient coverage.

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99 *Id.* at 302–04.

100 *Id.* at 309.

101 *Id.* at 302 ("The 14-day limitation will not deny respondents meaningful access to Tennessee Medicaid services or exclude them from those services.").

102 *See* Crossley, *supra* note 12, at 440–41 (concluding that the decision "saps much of the strength from 'disparate impact' arguments raised against the mandatory enrollment of disabled Medicaid recipients in a mainstream managed care program").

103 Leslie Pickering Francis & Anita Silvers, *Debilitating* Alexander v. Choate*: "Meaningful Access" to Health Care for People with Disabilities*, 35 FORDHAM URB. L.J. 447, 453 (2008) ("*Choate* leaves open a space in which 'meaningful access' can be defined. Crystallizing a strategy for defining this space is, we argue here, the critical step for plaintiffs to undertake in seeking to debilitate the effects of *Choate*.").

104 *See id.* at 452 (suggesting that none of the evidence presented by plaintiffs at trial to show discriminatory impact "was particularly convincing as to whether the facially-neutral fourteen-day limit excluded people with disabilities from a meaningful benefit.").

In addition, *Choate* explained that grantees may sometimes be required to make "reasonable modifications" to their program to meet § 504's requirement that grantees of federal funds provide people with disabilities "meaningful access" to the benefits the grantee offers.[105] *Choate* stated clearly what "meaningful access" did not require in that case. "Meaningful access" did not require the state to fundamentally alter its program by offering a benefit designed to equalize outcomes for disabled and nondisabled Medicaid recipients or by providing additional benefits to meet disabled recipients' greater medical needs.[106] So what *does* the "meaningful access" obligation require a state to do as it develops a cost-cutting strategy for its Medicaid program?

More specifically, what concrete meaning does this distinction between required "meaningful access" and nonobligatory "fundamental alterations" have when the benefit a state Medicaid program offers is not a specific item of coverage (such as payment for a specified length of hospital stay, for services provided by certain providers, or for a specific procedure or drug), but instead is enrollment in a managed care plan, which in turn contracts with the state to provide beneficiaries a broad range of benefits? What does it mean to provide disabled Medicaid recipients with "meaningful access" to the benefit of enrollment in a managed care plan? Interpreting a wide range of cases that have explained "meaningful access," Professors Francis and Silvers argue that *Choate*'s "meaningful access" standard poses the following question: Does the state offer a benefit in such a manner that people with disabilities do not have an equal opportunity to use or enjoy it, as compared to other recipients?[107] Reframing this question to apply to mandatory enrollment in Medicaid managed care, we can ask: What would keep disabled Medicaid recipients' "access" to enrollment in a managed care plan from being "meaningful"?

Reviewing analyses of mandatory Medicaid managed care for people with disabilities suggests several ways that their access to Medicaid-provided health care via enrollment in a managed care plan might turn out not to be meaningful.[108] First, disabled Medicaid recipients might be unable to use standard enrollment processes for the managed care plans that contract with the state Medicaid agency.[109] Recipients with vision, hearing, and intellectual impairments would not have meaningful access if a plan fails to provide auxiliary aids or other supports disabled persons need to use enrollment information and

105 *Choate*, 469 U.S. at 301 & n.21 (citing to regulations).

106 *Id.* at 302–06.

107 Francis & Silvers, *supra* note 103, at 453, 477; *see also* Alexander Abbe, *"Meaningful Access" to Health Care and the Remedies Available to Medicaid Managed Care Recipients Under the ADA and Rehabilitation Act*, 147 U. PA. L. REV. 1161, 1184–85 (1999); Laurence Paradis, *Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act: Making Programs, Services, and Activities Accessible to All*, 14 STAN. L. & POL'Y REV. 389, 399 (2003).

108 *See* NAT'L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES 111 (2009), *available at* http://www.ncd.gov/rawmedia_repository/0d7c848f_3d97_43b3_bea5_36e1d97f973d?document.pdf.

109 *See id.* at 111, 321.

materials.[110] Even under *Choate*, if the benefit a state provides its Medicaid recipients is enrollment in a managed care plan, the very least a state must do in order to avoid a disability discrimination claim is to ensure that readily available auxiliary aids and other supports give disabled recipients an equal opportunity to use plan enrollment processes.[111]

Second, disabled recipients may face access barriers when they seek care from physicians[112] who are in the limited network of providers available to them through their managed care plan. Providers' offices and equipment may be physically inaccessible to people with certain disabilities (e.g., mobility impairments or morbid obesity), or the providers may not be able to communicate effectively with deaf or hearing–impaired patients.[113] Professor Elizabeth Pendo's work explores both the persistent physical accessibility problems in medical providers' offices and a possible remedy under the ADA for those problems,[114] and recent research documents remaining barriers to accessibility for some patients with disabilities.[115] If a state requires disabled Medicaid recipients to enroll in a managed care plan, but the practices of the doctors who contract with that plan to provide services are inaccessible, the

110 *See id.* As a practical matter, if a state mandates enrollment in managed care for disabled Medicaid recipients, it may seem implausible that the state would not make the enrollment process as easy as possible for those recipients. If, however, the state leaves it to the contracting plans to handle enrollment of recipients, those plans may not have an incentive to ease the enrollment of disabled recipients who are likely to be expensive to cover. *See id.* at 104–06.

111 *Cf.* Clarkson v. Coughlin, 898 F. Supp. 1019, 1050 (S.D.N.Y. 1995) (finding, in class action brought by prisoners, "[d]ue to the absence of interpretive services and/or assistive devices at parole and grievance hearings, class members do not receive an opportunity to benefit from the grievance process and the parole program that is equal to that of non–disabled inmates"); United States v. Bd. of Trustees for Univ. of Ala., 908 F.2d 740, 748 (11th Cir. 1990) (distinguishing *Choate* in case involving university and finding that "in some instances the lack of an auxiliary aid effectively denies a handicapped student equal access to his or her opportunity to learn").

112 The reference here to "physicians" is shorthand for the broad group of providers on whom persons with disabilities rely for their medical and other needs, *e.g.*, physical therapists, audiologists, providers of durable medical equipment, to name just several.

113 *See* PEOPLE WITH DISABILITIES AND MEDICAID MANAGED CARE, *supra* note 8, at 7 (noting concerns regarding physical and communicational accessibility).

114 *See generally* Elizabeth Pendo, *Disability, Equipment Barriers, and Women's Health: Using the ADA to Provide Meaningful Access*, 2 ST. LOUIS U. J. HEALTH L. & POL'Y 15 (2008). The Affordable Care Act includes a provision calling for the development of access standards for medical diagnostic equipment such as examination tables and chairs, scales, and x–ray and mammography machines. Patient Protection and Affordable Care Act, § 4203, 29 U.S.C. § 794(f) (2012). In February 2012 the Access Board proposed a set of access standards, but as of this writing, the standards have not been finally adopted. *See Board Releases Proposed Standards for Medical Diagnostic Equipment*, U.S. ACCESS BOARD (Feb. 9, 2012), http://www.access-board.gov/news/163–board–releases–proposed–standards–for–medical–diagnostic–equipment.

115 *See* Tara Lagu et al., *Access to Subspecialty Care for Patients with Mobility Impairments*, 158 ANNALS INTERNAL MED. 441 (2013) (finding that many could not treat a patient who uses a wheelchair because they could not transfer the patient to an examination table); *see also* Pauline W. Chen, *Disability and Discrimination at the Doctor's Office*, N.Y. TIMES WELL BLOG (May 23, 2013), http://well.blogs.nytimes.com/2013/05/23/disability–and–discrimination–at–the–doctors–office.

state would seem not to have provided the disabled recipient with "meaningful access" to the benefit of coverage by a managed care plan.[116] If the "meaningful" modifier means anything, it must require something more than the bare access of being enrolled in a plan.

Third, medical and other services that a Medicaid managed care plan officially covers may not be accessible to disabled recipients if the plan's network does not include specialist physicians or other providers capable of providing those services.[117] In other words, a plan's contractual obligation to provide the specialized medical services needed by a Medicaid recipient with HIV and tuberculosis, or the supportive services needed by an elderly stroke survivor with early stage Alzheimer's, does not guarantee that those persons will actually be able to receive those services. As a practical matter, meaningful access to the relevant benefit—the services a state Medicaid program covers through managed care contracts—will depend on the availability of enough providers, with the needed expertise, within a reasonable geographic proximity to disabled Medicaid recipients.

If disabled Medicaid recipients challenge this third type of inaccessibility, *Choate* may present a real problem. Although advocates for people with disabilities can argue that, without enough specialized providers, disabled Medicaid enrollees do not have "meaningful access" to Medicaid-covered services, *Choate* suggests a ready counter-argument. The state can characterize the disabled enrollees as complaining that they do not benefit as much from managed care enrollment as do non-disabled enrollees.[118] Thus, the state could analogize the mandatory managed care complaint to the plaintiffs' claim in *Choate*: Enrollment in a managed care organization with a limited network disparately impacts people with disabilities (who tend to have complex medical needs) in the same way that a fourteen-day limitation on hospital inpatient coverage disparately impacts people with disabilities (who tend to need longer hospital stays).[119] Because the Supreme Court held that the latter argument

116 *Cf.* Anderson v. Dep't of Pub. Welfare, 1 F. Supp. 2d 456, 463–65 (E.D. Pa. 1998). When a doctor's office is inaccessible, a patient with a disability (whether a Medicaid recipient or not) may also have a claim against the doctor under Title III of the ADA, which applies to public accommodations. *See* NAT'L COUNCIL ON DISABILITY, *supra* note 108, at 101–03 (discussing lawsuits and settlement agreements addressing physical, equipment, and communications access barriers). The availability of an action directly against the provider, however, should not excuse the state from its obligation to provide disabled Medicaid recipients with an opportunity to benefit from enrollment in a managed care plan equal to the benefit enjoyed by non-disabled Medicaid recipients.

117 *See* Vanmala S. Hiranandani, *Disabling Health Care? Medicaid Managed Care and People with Disabilities in America*, 3 POVERTY & PUB. POL'Y, no. 2, art. 7, 2011, at 1, 10 (stating that most respondents in a qualitative research study reported that Medicaid managed care programs "often provide inadequate access to specialists who are qualified to diagnose and treat special health conditions"). This may be a particular concern for disabled dual eligibles required to enroll in a managed care plan that is supposed to provide the full range of services covered by both Medicare and Medicaid. *See* Neuman et al., *supra* note 35, at 1189.

118 *See, e.g.*, Alexander v. Choate, 469 U.S. 287, 303–04 (1985).

119 *Id.*

failed to state a cognizable claim under § 504, the former argument about Medicaid managed care is potentially vulnerable.[120]

This argument highlights the indeterminate nature of the standard the Court set out in *Choate*. Professor Sam Bagenstos captures this indeterminacy well in discussing the "access/content" distinction that courts have employed when deciding disability discrimination claims.[121] According to Bagenstos, a court that finds that disabled program participants are simply seeking *access* to the same benefit that non-disabled participants already receive will find that plaintiffs have stated a claim.[122] By contrast, a court that concludes that disabled plaintiffs are trying to force a program to change the *content* of its benefits package will likely reject the claim as seeking a "fundamental alteration" not required by *Choate*.[123] Of course, as Bagenstos highlights, the level of generality at which the relevant benefit is described will likely determine where a claim falls on the access/content divide.[124]

Despite its inherent indeterminacy, the access/content distinction suggests how the parties might frame their arguments in a lawsuit alleging that mandatory Medicaid managed care enrollment discriminatorily affects people with disabilities. The disabled plaintiffs would argue that they simply seek access to a benefit (i.e., enrollment in a plan providing the services covered by the state Medicaid program) that non-disabled Medicaid recipients already enjoy. By contrast, the state would argue that the lawsuit seeks to force it to fundamentally alter the content of its program by contracting with managed care plans with unusually extensive provider networks to meet the plaintiffs' greater medical needs. A court could plausibly accept either argument.[125]

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120 *Id.* at 289. *But cf.* Francis & Silvers, *supra* note 103, at 451–53 (suggesting that ADA's broader purpose—compared to the Rehabilitation Act—might support an outcome different from *Choate's*). In addition, as Professor Francis suggested to me, this defense breaks down if—as a result of a plan's lack of specialists needed to perform a covered service—people with disabilities cannot receive the covered service at all. *See id.* In that case, the better analogy under *Choate* would be the lack of meaningful access to a surgery that required a 15-day hospital stay.

121 *See* SAMUEL R. BAGENSTOS, LAW & THE CONTRADICTIONS OF THE DISABILITY RIGHTS MOVEMENT 70–74 (2009).

122 *Id.*

123 *Id.* Professor Rosenbaum makes a similar point, using slightly different language. *See* Rosenbaum et al., *Olmstead v. L.C.*, *supra* note 51, at 133 ("Once a court determines that what plaintiffs seek is a restructuring of the *design* of an insurance program, whether public or private, the fundamental alteration defense appears to be available.").

124 BAGENSTOS, *supra* note 121, at 72–74. *Choate* illustrates the level of generality point. The Court rejected the plaintiffs' claim that Medicaid enrollment entitled them to "adequate health care," a claim that described the relevant benefit at a very high level of generality. 469 U.S. at 303. Instead, the Court described the relevant benefit more specifically, as "a particular package of health care services, such as 14 days of inpatient coverage." *Id.*

125 If the plaintiffs present evidence that a lack of specialists keeps them from receiving the types of services that non-disabled Medicaid enrollees receive, then a court's acceptance of the state's argument is less plausible. Even in that case, however, the state is likely to characterize the covered benefit with a high level of specificity to show that plaintiffs have access to it.

If, however, disabled plaintiffs can argue that disability discrimination law entitles them to a benefit with specific features the state *itself* has already agreed are needed to assure access for disabled Medicaid beneficiaries, the state's "fundamental alteration" argument loses much of its force. And disabled plaintiffs' ability to invoke these existing commitments by states rests largely upon states' need to obtain waivers from CMS before they can compel disabled Medicaid beneficiaries to enroll in managed care. Hence my basic thesis: Access-related standards contained in CMS waivers permitting mandatory managed care enrollment of disabled Medicaid recipients—if not met—may give meaning to *Choate*'s "meaningful access" standard and thus enable recipients to enforce those standards using § 504 or the ADA. The following section will expand on and illustrate this point.

D. California's "Bridge to Reform" Waiver

California's recent movement of nearly a quarter of a million seniors and people with disabilities covered by Medi-Cal into managed care programs illustrates how a state's waiver obligations might lay the foundation for a disability discrimination action. As part of its "Bridge to Reform" demonstration project waiver,[126] between June 2011 and May 2012, California moved 240,000 elderly and disabled Medi-Cal recipients[127] (whom the State refers to as "Seniors and People with Disabilities" or SPD) out of fee-for-service settings and into managed care plans.[128]

126 The "Bridge to Reform," which is the most recent addition to an ongoing demonstration project in California under authority of a § 1115 waiver, seeks to assist the State's move towards implementation of the reforms associated with the Affordable Care Act. *See* State of California, California Section 1115 Comprehensive Demonstration Project Waiver, A Bridge to Reform: A Section 1115 Waiver Proposal (June 2010) [hereinafter Bridge to Reform Application], *available at* http://www.cdcan.us/medi-cal/Section1115Waiver/20100610-A%20Bridge%20to%20Reform%20 6-10-2010.pdf. Along with the mandatory movement of elderly and disabled persons into Medicaid managed care, the waiver also permits the state to extend coverage to more low-income adults and to support reforms of public and academic hospital delivery systems. *See* SAMANTHA ARTIGA & ANDY SCHNEIDER, KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., CALIFORNIA'S "BRIDGE TO REFORM" MEDICAID DEMONSTRATION WAIVER 1, 5 (2011), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8197-r.pdf. CMS approved the request in November 2010. Letter from Donald M. Berwick, M.D., Adm'r, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., to S. Kimberly Belshe, Sec'y, Cal. Health & Human Servs. (Nov. 2, 2010), *available at* http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CA%20Waiver%20Approval%20Letter.pdf.

127 The initial stage of the Bridge to Reform targeted seniors and people with disabilities who were covered only by Medi-Cal. The next stage would include the transition of dually eligible persons into managed care. *See* Bridge to Reform Application, *supra* note 126, at 2, 4.

128 This is the initiative that prompted the "*Huge Experiment Aims to Save on Care for Poorest, Sickest Patients*" headline. *See* Carey & Varney, *supra* note 2, at 1-2. An estimated 140,000 additional SPDs had previously enrolled in managed care plans voluntarily. Under the waiver, they could no longer switch back into the fee-for-service system. *See* PETER HARBAGE & MEREDITH LEDFORD KING, CAL. HEALTHCARE FOUND., A BRIDGE TO REFORM: CALIFORNIA'S MEDICAID SECTION 1115

Before it could require these Medi-Cal recipients to enroll in managed care plans—a move that in many cases disrupted existing provider-patient relationships[129]—California had to obtain a waiver from CMS. The State's request for approval acknowledged that using managed care plans to meet the complex medical and support needs of the SPD population would present challenges, and it set out a series of "Key Performance Standards for Plans Enrolling SPD Populations." These describe access-related standards addressing network adequacy, enrollee access to information, and physical accessibility, as well as standards addressing care management and coordination along with performance monitoring and improvement.[130]

CMS approved California's Bridge to Reform demonstration project, but conditioned its approval on the State's accepting an extensive list of "Special Terms and Conditions," including ten pages specifically detailing requirements for managed care delivery systems for SPD.[131] These Special Terms and Conditions require continuing consultation with the State and CMS to ensure that managed care plans contracted to serve mandatorily enrolled SPDs exhibit "plan readiness."[132] The following are examples of access-related items needed for plan readiness: a specialty provider pool sufficient to meet the unique needs of plan enrollees; a network that, considering the means of transportation that SPDs ordinarily use, is geographically accessible; the completion of facility site reviews to ensure physical accessibility; and the availability of interpreter services.[133] The precise details of the application and the Special Terms and Conditions matter little for this Article's central contention. What does matter is that California committed itself to extensive steps to ensure that disabled Medi-Cal recipients, enrolled in managed care, could actually access services covered by Medi-Cal.[134]

WAIVER 22 (2012), *available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/B/PDF%20BridgeToReform1115Waiver.pdf.

129 For anecdotal accounts of enrollees' concerns about the impact of this disruption on their care, see Carey & Varney, *supra* note 2, at 1, 4, 5.

130 *See* Bridge to Reform Application, *supra* note 126, at 44–47.

131 *See* CTRS. FOR MEDICARE & MEDICAID SERVS., No. 11-W-00193/9, CALIFORNIA BRIDGE TO REFORM DEMONSTRATION: SPECIAL TERMS AND CONDITIONS 32–42 (2013) [hereinafter SPECIAL TERMS AND CONDITIONS], *available at* http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Publications/CaliforniaSTCs11-2-10.pdf. California's request for approval of the Bridge to Reform Demonstration Project was seventy-one pages long. The Special Terms and Conditions that CMS developed for the demonstration project ran to 116 pages.

132 *Id.* at 37.

133 *Id.* at 37–39.

134 Prior to submitting its waiver request, the California Department of Health Care Services convened a workgroup including consumer advocates to address concerns about expanding mandatory managed care for elderly and disabled Medi-Cal recipients. For a description of the process and resulting performance standards for managed care plans contracted to serve those Medi-Cal recipients, see KATHY MOSES, CAL. HEALTHCARE FOUND., RAISING THE BAR: HOW MEDI-CAL STRENGTHENED MANAGED CARE CONTRACTS FOR PEOPLE WITH DISABILITIES 2 (2012), *available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/R/PDF%20RaisingBar-

Notwithstanding the extensive assurances that emerged from the process of application and conditional approval, early assessments of the Bridge to Reform's implementation found that some enrollees experienced troubling problems, including difficulty in understanding communications about the transition and managed care plans that were ill equipped to address complex conditions.[135] This early review is not surprising, especially in light of California's aggressive implementation timetable. Implementing and monitoring standards to ensure access for disabled Medicaid recipients undoubtedly present greater challenges than developing those standards. And, as a practical matter, any state may be unable to entirely avoid having some individual disabled Medicaid recipients experience serious ill effects from having to transition to managed care.[136]

A disparate impact disability discrimination claim, however, does not focus on the effect that any individual enrollee experiences.[137] Instead, this Article proposes that one way for disability advocates to frame a disparate impact claim is to ask whether the state (and its managed care contractors) have effectively carried out the state's representations to CMS about how it will ensure that disabled Medicaid recipients—as a group—have access to covered services. If not, those recipients can claim that compelling them to enroll in managed care deprived them of "meaningful access" to the benefit a state Medicaid program provides (i.e., a set of covered services). In short, the plaintiffs can establish what "meaningful access" requires by employing the state's own commitments regarding the access-related safeguards it would undertake.[138]

ManagedCareContractsSPD.pdf.

135 *See* HARBAGE & KING, *supra* note 128, at 22, 27; KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., TRANSITIONING BENEFICIARIES WITH COMPLEX CARE NEEDS TO MEDICAID MANAGED CARE: INSIGHTS FROM CALIFORNIA 4–5 (2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8453-transitioning-beneficiaries-with-complex-care-needs2.pdf.

136 For anecdotal accounts of these difficulties, see Carey & Varney, *supra* note 2. California's waiver permits SPD beneficiaries who enroll in managed care to receive care from an existing provider for one year and to seek an exemption from enrollment for a year if they have specific medical conditions, but consumer advocates assert that these policies were confusing and inconsistently applied. *See* HARBAGE & KING, *supra* note 128, at 24, 27.

137 For example, the successful disparate impact claim in *American Council of the Blind v. Paulson*, 525 F.3d 1256 (D.C. Cir. 2008), was based on the failure of the U.S. Treasury to design and issue paper currency that is readily distinguishable to people with visual impairments. The complaint alleged that "for millions of Americans with blindness or low vision, it is impossible to recognize the denomination of banknotes." *Id.* at 1261.

138 This proposed reliance on the State's own standards, however, should not be understood as the exclusive avenue for a successful disparate impact claim. In particular, times may exist when a State's own standards, even if approved by CMS and fully implemented, would not sufficiently address the access issues that disabled Medicaid beneficiaries are likely to encounter when compelled to enroll in managed care. As Professor Leslie Francis suggested to me, this concern regarding inadequate state standards may become more immediate if CMS grows more lenient in granting waivers in order to encourage states to participate in the ACA's Medicaid expansion. *Cf.* Laura D. Hermer, *Federal/State Tensions in Fulfilling Medicaid's Purposes*, 21 ANNALS HEALTH L. 615, 636–37 (2012) (cautioning that CMS should not grant waivers that are inconsistent with Medicaid's pur-

Framing the claim to incorporate the state's own representations should help plaintiffs avoid a characterization—fatal under *Choate*—that they are simply complaining that the benefit the state has chosen to provide does not fully meet their more complex medical needs. Instead, plaintiffs can argue that a state's failure to live up to its own access-related commitments keeps disabled plaintiffs from enjoying the same chance as other Medicaid recipients to benefit from enrollment in a Medicaid managed care plan. Another way of stating this argument is that, by agreeing to access-related terms of a waiver, the State accepts those adaptations of its Medicaid managed care program as "reasonable"; the flip side of this analytic coin is that these steps do *not* reflect fundamental alterations to the State's program.

California's "Bridge to Reform" offers just one example of a state seeking CMS approval to require the enrollment of large numbers of disabled Medicaid beneficiaries in managed care plans; a number of other big states are on the same path.[139] CMS has signaled that it expects states making waiver applications to propose specific provisions about protections for people with disabilities.[140] And when a state represents to CMS the steps it will take to make sure disabled Medicaid recipients have access to the services Medicaid covers, the state's failure to take those steps can be framed as the state's failure to provide meaningful access. Using this approach to give meaning to "meaningful access" in the context of Medicaid managed care offers several benefits to advocates for disabled Medicaid beneficiaries, but does not assure success, as the next Part briefly outlines.

IV. Could This Approach Work?

A. The Benefits of Emphasizing Waiver Commitments in a "Meaningful Access" Claim

As discussed above, *Choate*'s rejection of any assertion that the benefit Medicaid provides is "adequate health care" presents an obstacle to pursuing a claim that mandatory enrollment in Medicaid managed care has an adverse disparate impact on people with disabilities. In short, states facing such a claim can argue that as long as disabled Medicaid beneficiaries are able to enroll in a managed care plan they have accessed the benefit that Medicaid provides. This argument builds on a reading of *Choate* that emphasizes the point that disabled Medicaid beneficiaries, like other Medicaid beneficiaries, received and benefited

pose of ensuring access to care).

139 *See* People with Disabilities and Medicaid Managed Care, *supra* note 8, at 14 (noting Texas's enrollment of disabled recipients into managed care); Iglehart, *supra* note 25, at 1627 (noting Florida's and New York's plans to shift all Medicaid beneficiaries into managed care).

140 *See* Iglehart, *supra* note 25, at 1629 (noting that, in granting California's waiver, "[former] CMS administrator Donald Berwick underscored the safeguards with which plans must abide and the state must enforce").

from the fourteen days of inpatient hospital coverage provided by Tennessee.[141] For several reasons, however, a contemporary challenge to mandatory managed care enrollment—if it focuses on the access-related commitments[142] made by a state in a waiver application to CMS—would seem to have better prospects of success.

First and foremost, because states must obtain a waiver before they can mandate the enrollment of many disabled Medicaid beneficiaries in managed care, a process is already in place by which states themselves describe the steps they will take to ensure that disabled beneficiaries realistically have access to the services that managed care plans have contracted to cover. The policy literature has thoroughly analyzed the distinctive access issues that Medicaid managed care presents for people with disabilities, as well as steps to help ensure access,[143] and it stands to reason that states and CMS will take this into account in making and conditionally granting waiver applications. CMS leadership has already emphasized that states need to address the access needs of people with disabilities in their waivers.[144] As states seeking waivers make commitments to CMS about what they will do to ensure access, the states themselves are providing specific content to what "meaningful access" to Medicaid managed care consists of. These prescriptions for "meaningful access" are far removed from the nebulous concept of "adequate health care" that *Choate* deemed an inadequate basis for a claim.

Moreover, it is not simply the specificity of access-related representations in waivers that will help distinguish a contemporary challenge from *Choate*. It is also the "ownership" that state Medicaid officials take of the protections through the process of negotiating a waiver's approval by CMS. In *Choate*, Justice Marshall expressed a concern about interpreting § 504 in a fashion that intrudes on resource allocation decisions that the Medicaid statute entrusted to the states.[145] As he wrote: "[T]o require that the sort of broad-based distributive decision at issue in this case always be made in the way most favorable, or least disadvantageous, to the handicapped . . . would be to impose a virtually

141 *See* Francis & Silvers, *supra* note 103, at 448–49, 453. Francis and Silvers have argued that it is more accurate to read *Choate* as a fact-specific holding in response to the plaintiffs' failure to provide strong evidence of an actual disparate impact and, thus, to show a lack of meaningful access. *Id.*

142 Some of the representations that a state makes will likely relate more to the quality of care that is provided and its coordination than to access to providers, services, or physical facilities. While the quality and coordination of care are also important to disabled Medicaid beneficiaries, failures in these areas would be more difficult to characterize as failures of meaningful access.

143 *See, e.g.*, PEOPLE WITH DISABILITIES AND MEDICAID MANAGED CARE, *supra* note 8, at i–iii; *see also* LIPSON ET AL., *supra* note 44, at 1, 6, 8 (noting four guiding principles that States should consider); NCD ANALYSIS AND RECOMMENDATIONS, *supra* note 44, at 1, 6–10 (making recommendations regarding possible implementation plans); NCD POLICY AND IMPLEMENTATION CONSIDERATIONS, *supra* note 44, at 59–130 (setting forth 22 principles to "guide the design and implementation of managed care for people with disabilities").

144 *See* HARBAGE & KING, *supra* note 128, at 2.

145 *See* Alexander v. Choate, 469 U.S. 287, 308 (1985).

unworkable requirement on state Medicaid administrators."[146] Justice Kennedy's concurrence in *Olmstead v. Zimring*[147] sounded a similar theme. Although that case did not directly concern Medicaid, *Olmstead*'s finding, that unnecessary institutionalization of persons with mental disabilities in state facilities violated the ADA, implicated the broader concern about federal courts directing state program administrators.[148]

A disparate impact challenge based on harms to disabled Medicaid beneficiaries from their mandatory enrollment in managed care could easily provoke a similar reaction. However, framing the challenge in terms of the state's failure to satisfy its own waiver commitments could blunt this federalism defense. Because the plaintiffs' yardstick for what the state must do to make access meaningful would be based on the state's own commitments, the federal courts would not be making decisions with resource implications for the state. Instead, the court would simply be considering whether the state had lived up to the commitments that its own officials made.

Finally, if the suggested reliance on the state's own waiver commitments succeeds in overcoming any *Choate*-based defenses, disability discrimination claims alleging the failure of managed care to provide "meaningful access" to Medicaid-covered benefits could supply an important avenue of recourse against a state Medicaid program. Since 2002, when the Supreme Court limited private plaintiffs' ability to use 42 U.S.C. § 1983 to enforce funding conditions in federal statutes,[149] lower courts have stripped Medicaid beneficiaries of their ability to sue state agencies for failing to comply with the requirements of the federal Medicaid statute.[150] Although courts have found that some provisions in the Medicaid statute evince Congress' intent to create enforceable rights in Medicaid beneficiaries,[151] since 2002 most federal courts of appeal have denied private enforcement of a provision designed to ensure beneficiaries' access to providers.[152] Moreover, courts might find that the increasing latitude that Congress has granted states to move Medicaid beneficiaries into managed care is incompatible with Congressional intent to create private rights against the state on the part of the Medicaid beneficiaries dissatisfied with their managed

146 *Id.*

147 Olmstead v. L.C. *ex rel.* Zimring, 527 U.S. 581, 608, 610–11 (1999) (Kennedy, J., concurring).

148 *Id.* at 610 (noting "the federalism costs inherent in referring state decisions regarding the administration of treatment programs and the allocation of resources to the reviewing authority of the federal courts").

149 Gonzaga Univ. v. Doe, 536 U.S. 273, 276 (2002).

150 Abigail R. Moncrieff, *The Supreme Court's Assault on Litigation: Why (and How) It Might Be Good for Health Law*, 90 B.U. L. REV. 2323, 2332–34 (2010); *see* Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 425–26, 442–43 (2008).

151 Moncrieff, *supra* note 150, at 2334 n.44.

152 *Id.* at 2333 & nn.36–37. The so-called "Equal Access Provision" requires States to reimburse providers at a level high enough to ensure that Medicaid beneficiaries have access to providers that is equal to that of other patients in their region. *Id.*

care experience.[153] Most recently, the Supreme Court avoided deciding whether Medicaid beneficiaries can bring suit under the Supremacy Clause to challenge a state law alleged to conflict with the Medicaid statute.[154] For these reasons, the ability of Medicaid beneficiaries to enforce the Medicaid statute is highly doubtful. But disabled plaintiffs' standing to sue to enforce the Rehabilitation Act and the ADA is well established.

B. Reasons To Be Less Sanguine

The foregoing discussion suggests that, notwithstanding *Choate*, advocates may be able to pursue a disability discrimination claim if disabled Medicaid beneficiaries are compelled to enroll in managed care plans that fail to provide access to needed facilities and providers. But even if a court accepts that disabled plaintiffs can pursue this avenue for relief, this approach does not assure success in addressing the challenges that disabled Medicaid beneficiaries may face as they transition into managed care settings. For several reasons, both legal and practical, the relief a claim based on this theory realistically provides may be limited.

Although focusing on the access-related commitments in state waiver applications distinguishes a challenge by people with disabilities compelled to enroll in Medicaid managed care from the challenge advanced in *Choate*, a state may still argue that the access protections it agreed to in order to obtain a waiver from CMS go above and beyond what *Choate*'s "meaningful access" standard requires. In other words, the state might argue that its waiver commitments would provide some ideal level of access and that, therefore, its failure to live up to those commitments does not necessarily equate to a failure to provide "meaningful access." Although a state advancing this defense risks appearing disingenuous, predicting a court's response is difficult.

Even if a court accepts the proposition that a state's waiver commitments supply the standards for judging what "meaningful access" requires, the plaintiffs' case may depend on those commitments being sufficiently articulated to provide definite standards.[155] For example, California's request for approval

153 *See* Devi M. Rao, Note, *"Making Medical Assistance Available": Enforcing the Medicaid Act's Availability Provision Through § 1983 Litigation*, 109 COLUM. L. REV. 1440, 1441–43 (2009).

154 *See* Douglas v. Indep. Living Ctr. of S. Cal., Inc., 132 S. Ct. 1204, 1210 (2012). *See generally* Katherine Moran Meeks, Case Note, *Private Enforcement of Spending Conditions After* Douglas, 161 U. PA. L. REV. PENNUMBRA 56, 57 (2012), http://www.pennlawreview.com/online/161-U-Pa-L-Rev-PENNumbra-56.pdf (indicating that some scholars believe the Supremacy Clause may be relevant in considering these claims).

155 *Cf.* NCD ANALYSIS AND RECOMMENDATIONS, *supra* note 44, at 7 (recommending that readiness assessment conducted by CMS prior to approving a waiver should include "performance benchmarks to be used in measuring access to services").

of its "Bridge to Reform" demonstration contained the following language regarding network adequacy:

> Network adequacy for the enrollment of SPDs will require sufficient specialists necessary to care for the specialized needs of this population consistent with the Department of Managed HealthCare and DHCS processes and any enhancements DHCS deems necessary to further support the case of the SPDs.[156]

While it sounds reassuring, this language does not provide specific benchmarks that would permit a court to determine whether network adequacy had been achieved. By contrast, the Special Terms and Conditions required by CMS as a condition of approving California's waiver provide some greater specificity in their reference to applicable federal and state regulations and data sources for assessing adequacy,[157] but even they cannot anticipate a definite number of each type of provider. While the absence of a definite "meaningful access" standard is not necessarily fatal, a court asked to decide whether a plan's specialist network in fact provides meaningful access may have qualms about intruding on the territory of state program administrators.

Moreover, even if a state's waiver commitments easily translate into measurable benchmarks for "meaningful access," determining whether a state is failing to live up to its commitments in a way that is actionable may be difficult. A disparate impact cause of action alleging a state's failure to provide "meaningful access" essentially asserts that compelling disabled Medicaid recipients to enroll in managed care plans has an adverse impact on them *as a group* that exceeds the harms experienced by other Medicaid managed care enrollees. Showing that an individual disabled Medicaid beneficiary, after the transition to managed care, is no longer able to see a needed specialist will not, by itself, support a claim against the state for failure to provide meaningful access.[158] Instead, plaintiffs must show group disadvantage flowing from their required enrollment in managed care. Developing that proof depends on systemic monitoring of the implementation of managed care for people with disabilities and reporting its results. While a state's waiver application is likely to include commitments to engage in monitoring and reporting, commentators express concerns about how vigorously resource-strapped state Medicaid

156 *See* Bridge to Reform Application, *supra* note 126, at 45.

157 *See* SPECIAL TERMS AND CONDITIONS, *supra* note 131, at 44–45, 56.

158 Some overlap, however, may exist in situations involving physical accessibility that would support a disability discrimination claim by an individual disabled plaintiff and a disparate impact claim by a group of disabled plaintiffs. For example, the failure of a doctor's practice to remove physical barriers to its facilities or to provide equipment that is accessible may be the basis for an individual ADA Title III claim against the practice. If the doctors' practices making up the physician network for a managed care plan that has contracted with a state to provide Medicaid coverage consistently fail to remove barriers or provide accessible equipment, then disabled Medicaid recipients may argue that this systemic lack of access demonstrates the disparate impact they suffer from compulsory managed care enrollment.

agencies will be able to monitor implementation.[159] And without systemic monitoring and reporting, plaintiffs trying to prove a disparate impact may have little more than anecdotes as evidence.

Finally, this Article's suggested approach to pursuing a disability discrimination claim applies only when a state seeks CMS approval to move disabled Medicaid beneficiaries into managed care.[160] If a state can compel disabled Medicaid recipients to enroll in managed care plans without going through the waiver process, as it can for adults with disabilities who are not dual eligibles, then the state may have no need to make access-related commitments. Without these commitments, *Choate's* reasoning may remain a substantial barrier to any suit.[161] Because Congress has gradually made it easier for states to mandate managed care enrollment for Medicaid recipients, some disabled Medicaid beneficiaries have already been moved into managed care without the need for a waiver.[162] Currently, however, states must still obtain a waiver before mandating the enrollment of children with special needs and persons who are dual eligibles, categories that represent a substantial fraction of disabled Medicaid beneficiaries.[163] If Medicaid were transformed into a block grant program, as some have proposed,[164] then CMS would likely no longer play any gatekeeper role with respect to states' ability to transform their Medicaid programs.

C. Still an Idea Worth Pursuing?

Despite these potential limitations on the robustness of a theory of disability discrimination liability that depends on states' waiver commitments to ensure access for disabled Medicaid beneficiaries compelled to enroll in managed care, disability advocates should prepare to pursue this theory as the Medicaid managed care "juggernaut" advances.[165] Part of the challenge of this theory, but also one of its strengths, is that it reinforces just how crucial involvement of and advocacy by disability rights groups are throughout the transition process. Advocacy groups have already been heavily involved, and continued involvement will be critical: suggesting standards to be used in waiver applications, engaging with CMS officials as they review applications, monitoring the implementation

159 NCD ANALYSIS AND RECOMMENDATIONS, *supra* note 44, at 2; Neuman et al., *supra* note 35, at 1191.

160 MOSES, *supra* note 134, at 2, 3, 6. (Furthermore, this article's suggested approach only applies when the state's standards are sufficiently high to address the access challenges that people with disabilities are likely to face when required to enroll in Medicaid managed care.).

161 *See supra* Part III.C.

162 *See* Iglehart, *supra* note 25, at 1628.

163 *See* MEDICAID AND MANAGED CARE 2010, *supra* note 7, at 1.

164 *See* Robert Pear, *G.O.P. Blueprint Would Remake Health Policy*, N.Y. TIMES, Apr. 4, 2011, at A1 (describing Ryan budget plan proposals).

165 Iglehart, *supra* note 25, at 1629.

of Medicaid managed care for people with disabilities, and disseminating the results.

The value of monitoring and reporting, however, extends well beyond the possibility of establishing the basis for a disability discrimination claim. It will not be until the enrollment of people with disabilities in Medicaid managed care becomes more widespread and uniform that researchers and policymakers will be able to assess what works—and what does not—in the effort to fulfill, to the utmost extent, the promise of Medicaid managed care for people with disabilities while avoiding as much as possible its perils.[166] As this process unfolds, monitoring the effects of compelled enrollment on this population may help fill the existing knowledge void about how to manage and coordinate the care of people with disabilities to best promote their health while controlling costs.

Conclusion

Inevitably, the process of figuring out what works and what does not in providing Medicaid managed care to persons with disabilities will have an element of trial and error. As this occurs, however, disability discrimination law may provide an important backstop to ensure that state agencies do not ignore problems that may arise, but instead engage in close oversight and remedial action as they attempt to figure out what works. To be sure, to the extent that all Medicaid recipients have reason to worry about their health care because of state budgetary woes and limitations imposed by managed care, disability discrimination law does not provide any special protection for people with disabilities. It does not give them any right to suffer less from these challenges than do their fellow non-disabled Medicaid recipients.

If, however, a state rushes to enroll its disabled Medicaid recipients into managed care in a way that quite predictably leaves them without access to the care that Medicaid promises to cover,[167] then disability discrimination law may play an important role in countering the state's disregard for its failure to ensure access. Disabled Medicaid beneficiaries should be able to frame a disparate impact claim by relying on the state's own commitments in its Medicaid waiver applications in order to give meaning to the "meaningful access" that § 504 and the ADA require.

166 *See* Iglehart, *supra* note 25, at 1628 (quoting Diane Rowland, chair of Medicaid and CHIP Payment and Access Commission, noting importance of assessing the impact of managed care enrollment on "sicker and more frail populations").

167 *Cf.* Neuman et al., *supra* note 35, at 1186, 1190 (cautioning, with respect to the enrollment of dual eligibles in managed care, that time is needed for developing infrastructure and resources).