

PROMOTING HEALTH CARE EQUITY: THE INSTRUMENTALITY OF MEDICARE AND MEDICAID IN FIGHTING ABLEISM WITHIN THE AMERICAN HEALTH CARE SYSTEM

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I. INTRODUCTION

Over twenty million American adults have a disability that affects their functional mobility—a number that is expected to grow based on current health trends.¹ Despite this statistic, research shows that individuals with physical disabilities struggle to obtain health care services comparable to the services that able-bodied Americans receive.² Decades after the passing of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (“Section 504”),³ ableism in the form of physical inaccessibility remains a major barrier to equitable health care.⁴ Individuals with disabilities are being examined while seated in their wheelchairs due to difficulty transferring them to standard height examination tables,⁵ prescribed medication dosages based on their estimated weight rather than their actual weight due to their physician’s failure to obtain accessible

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¹ NAT’L COUNCIL ON DISABILITY, ENFORCEABLE ACCESSIBLE MEDICAL EQUIPMENT STANDARDS: A NECESSARY MEANS TO ADDRESS THE HEALTH CARE NEEDS OF PEOPLE WITH MOBILITY DISABILITIES 13 (2021) [hereinafter NCD, ACCESSIBLE MEDICAL EQUIPMENT].

² See DEP’T OF HEALTH & HUM. SERVS., ADMIN. FOR CMTY. LIVING, WHEELCHAIR-ACCESSIBLE MEDICAL DIAGNOSTIC EQUIPMENT: CUTTING EDGE TECHNOLOGY, COST-EFFECTIVE FOR HEALTH CARE PROVIDERS, AND CONSUMER-FRIENDLY 1–2 (2023), <https://aahd.us/wp-content/uploads/2019/08/ACLMedicalDiagnosticEquipwheelchairaccessibility-July2019.pdf>.

³ See 42 U.S.C. §§ 12101–12213; 29 U.S.C. § 794.

⁴ CTRS. FOR MEDICARE & MEDICAID SERVS. OFF. OF MINORITY HEALTH, INCREASING THE PHYSICAL ACCESSIBILITY OF HEALTH CARE FACILITIES 2 (2017) [hereinafter CMS, INCREASING PHYSICAL ACCESSIBILITY].

⁵ See Michael D. Stillman et al., *Healthcare Utilization and Associated Barriers Experienced by Wheelchair Users: A Pilot Study*, 10 DISABILITY & HEALTH J. 502, 504 (2017).

scales,⁶ and forced to forego important preventative cancer screenings due to inaccessible radiological equipment.⁷ To achieve equity in health care for Americans with disabilities, all health care facilities must obtain accessible medical equipment.

Accessible medical equipment is equipment used for medical diagnosis and treatment purposes designed to accommodate the needs of people with disabilities or other mobility limitations.⁸ This includes examination tables that adjust in height to make it safer for patients to transfer from a wheelchair, mammography equipment that does not require the patient to stand, and weight scales that can accommodate a wheelchair, among others.⁹ Accessible medical equipment is necessary to provide individuals with physical disabilities adequate health care services.¹⁰ Therefore, until all health care facilities obtain such equipment, “health care disparities between people with physical disabilities and their nondisabled counterparts” will continue to exist.¹¹

The fact that this issue persists despite the existence of federal laws that require accessible health care indicates that stronger enforcement of these laws is necessary.¹² Without more aggressive enforcement, “health care providers are unlikely to alter their practices and acquire accessible medical equipment, as they have yet to do so notwithstanding the exist[ence of these] federal nondiscrimination mandates.”¹³ This Comment argues that because of the large number of Americans with disabilities insured under Medicare and Medicaid,¹⁴ as well as the large number of health care

⁶ Daryle J. Gardner-Bonneau & June Isaacson Kailes, *Accessible Health Care: More Than Just Getting Through the Door*, 18 *ERGONOMICS DESIGN* 5, 6 (2010).

⁷ See NCD, ACCESSIBLE MEDICAL EQUIPMENT, *supra* note 1, at 18.

⁸ Standards for Accessible Medical Diagnostic Equipment, 82 Fed. Reg. 2810, 2810 (Jan. 9, 2017).

⁹ NCD, ACCESSIBLE MEDICAL EQUIPMENT, *supra* note 1, at 2.

¹⁰ See Standards for Accessible Medical Diagnostic Equipment, 82 Fed. Reg. at 2811.

¹¹ NCD, ACCESSIBLE MEDICAL EQUIPMENT, *supra* note 1, at 2.

¹² See OFF. OF DISEASE PREVENTION & HEALTH PROMOTION, THE ROLE OF LAW AND POLICY IN ACHIEVING HEALTHY PEOPLE’S DISABILITY AND HEALTH GOALS AROUND ACCESS TO HEALTH CARE, ACTIVITIES PROMOTING HEALTH AND WELLNESS, INDEPENDENT LIVING AND PARTICIPATION, AND COLLECTING DATA IN THE UNITED STATES 58 (2020).

¹³ NCD, ACCESSIBLE MEDICAL EQUIPMENT, *supra* note 1, at 8.

¹⁴ See CTRS. FOR MEDICARE & MEDICAID SERVS., 2020 MEDICAID AND CHIP BENEFICIARY PROFILE: CHARACTERISTICS, HEALTH STATUS, ACCESS, UTILIZATION, EXPENDITURES, AND EXPERIENCE 15 (2021), <https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-profile-2021.pdf> (“Persons with disabilities account for 15%

facilities that participate in these programs,¹⁵ enforcement of the ADA and Section 504 through these programs would significantly reduce the problem of inaccessible health care.

Because of the financial leverage that the Medicare program gives the federal government over health care providers, it “has become the primary vehicle to bring health care entities under compliance with civil rights laws.”¹⁶ The Johnson Administration recognized the enforcement power of the Medicare program since it was first signed into law in 1965.¹⁷ By refusing to release Medicare funds to hospitals that did not comply with Title VI of the Civil Rights Act of 1964, the Johnson Administration successfully fought racism within the health care system, integrating the American hospitals in just four months.¹⁸ Using the actions of the Johnson Administration as a model, the Medicare and Medicaid programs should be used to enforce the ADA and Section 504 and fight ableism within the health care system by conditioning the receipt of these federal funds on provider compliance in obtaining accessible medical equipment.

Part II of this Comment discusses the issue of inaccessible medical equipment and the extent to which it remains unresolved. Part III summarizes the federal laws that are intended to prevent discrimination on the basis of disability and examines how, due to underenforcement, these laws have failed to effectively address health care disparities. Part IV discusses how government-run health

of Medicaid beneficiaries (10.6 million).”); *Distribution of Medicare Beneficiaries by Eligibility Category*, KAISER FAM. FOUND. (2019), <https://www.kff.org/medicare/state-indicator/distribution-of-medicare-beneficiaries-by-eligibility-category-2/?dataView=1¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (indicating that over 8.1 million Medicare Part A or Part B beneficiaries in 2020 had a disability).

¹⁵ See Cristina Boccuti et al., *Primary Care Physicians Accepting Medicare: A Snapshot*, KAISER FAM. FOUND. (Oct. 30, 2015), <https://www.kff.org/medicare/issue-brief/primary-care-physicians-accepting-medicare-a-snapshot> (stating that 93 percent of non-pediatric primary care physicians participate in Medicare and 67 percent participate in Medicaid). Requiring that these facilities obtain accessible medical equipment will not only benefit individuals that are beneficiaries of the Medicare and Medicaid programs; it will also benefit individuals that are not beneficiaries of these programs but are patients of facilities that participate in Medicare and Medicaid.

¹⁶ Valarie K. Blake, *Health Care Civil Rights Under Medicare for All*, 72 HASTINGS L.J. 773, 788 (2021).

¹⁷ See Jill Quadagno, *Promoting Civil Rights Through the Welfare State: How Medicare Integrated Southern Hospitals*, 47 SOC. PROBS. 68, 81 (2000).

¹⁸ See *id.*; see also David Barton Smith, *The “Golden Rules” for Eliminating Disparities: Title VI, Medicare, and the Implementation of the Affordable Care Act*, 25 HEALTH MATRIX 33, 49–52 (2015).

insurance programs, such as Medicare, can be used to promote equitable health care for minorities. After providing a brief description of the Medicare program, this Part then discusses how the Johnson Administration used Medicare funding to enforce Title VI of the Civil Rights Act of 1964 to desegregate American hospitals. Part V discusses how, using the Johnson Administration's actions as a model, the Centers for Medicare and Medicaid Services (CMS) can enforce Section 504 and the ADA by requiring that Medicare and Medicaid providers obtain equipment that is accessible to their patients with disabilities. Finally, Part VI briefly concludes.

II. RESEARCH INDICATES THAT MANY HEALTH CARE FACILITIES LACK ACCESSIBLE MEDICAL EQUIPMENT

The unavailability of accessible medical equipment is recognized as a “fundamental barrier” to equitable health care for individuals with disabilities.¹⁹ The failure to ensure that health care facilities are physically accessible affects the quality of care that patients with disabilities receive, “leading to delayed and incomplete care, missed diagnoses, exacerbation of the original disability, and increases in the likelihood of the development of secondary conditions.”²⁰ Accordingly, accessible medical equipment is necessary to provide individuals with disabilities health care services that are equal to what an able-bodied patient would receive.²¹ Yet research indicates that such equipment is often unavailable in health care facilities.²²

A. Examination Tables

Examination tables are typically necessary for a doctor to thoroughly examine their patient.²³ If a physician cannot transfer their

¹⁹ 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, 20 (2008) [hereinafter *Disability, Equipment Barriers, and Women's Health*].

²⁰ NCD, ACCESSIBLE MEDICAL EQUIPMENT, *supra* note 1, at 7.

²¹ Nondiscrimination on the Basis of Disability by State and Local Governments and Places of Public Accommodation; Equipment and Furniture, 75 Fed. Reg. 43,452, 43,455 (July 26, 2010).

²² See Stillman et al., *supra* note 5; Nancy R. Mudrick et al., *Presence of Accessible Equipment and Interior Elements in Primary Care Offices*, 3 HEALTH EQUITY 275, 275–76 (2019); Lisa I. Iezzoni et al., *Use of Accessible Weight Scales and Examination Tables/Chairs for Patients with Significant Mobility Limitations by Physicians Nationwide*, 47 JOINT COMM'N J. ON QUALITY & PATIENT SAFETY 615, 615 (2021).

²³ Guy Fragala et al., *Benefits Achieved for Patients Through Application of Height-Adjustable Examination Tables*, 4 J. PATIENT EXPERIENCE 138, 139 (2017).

patient onto an examination table, the physician may miss an early indicator of a serious developing condition or may misdiagnose the patient because they could not obtain sufficient information.²⁴ Yet standard examination tables are built at a height of thirty-two inches while the normal height of a wheelchair is about eighteen inches,²⁵ making it difficult and unsafe for patients to transfer from their wheelchairs onto the examination table.²⁶ Although tables that are adjustable in height may assist physicians in providing adequate health care to their patients with physical disabilities,²⁷ research suggests that such equipment is often unavailable.

In a 2017 survey of 432 adult wheelchair users, 69.7 percent reported that they were examined by their physician while seated in their wheelchair rather than on an examination table.²⁸ Additionally, in a 2021 nationwide survey of 714 physicians, only 19 percent reported that they always use an accessible examination table or chair, compared to 40.8 percent that never use an accessible examination table or chair.²⁹ Consequentially, many individuals are not receiving the equitable health care that physicians are legally required to provide due to the lack of height-adjustable examination tables.

B. Scales

Body weight measurement is “a routine part of medical examinations and is important to [a] patient’s health and medical care.”³⁰ An accurate weight measurement is necessary to properly measure medication dosages for a patient.³¹ Additionally, a patient’s weight is a major indicator of many reproductive or hormonal problems, cardiovascular diseases, cancer, high blood pressure, and

²⁴ *Id.*

²⁵ *Id.* at 138.

²⁶ See *Disability, Equipment Barriers, and Women’s Health*, *supra* note 19, at 24.

²⁷ See U.S. DEP’T OF JUST. & U.S. DEP’T OF HEALTH & HUM. SERVS., AMERICANS WITH DISABILITIES ACT: ACCESS TO MEDICAL CARE FOR INDIVIDUALS WITH MOBILITY DISABILITIES 2 (2010) [hereinafter DOJ & HHS, ACCESS TO MEDICAL CARE], <https://www.hhs.gov/sites/default/files/ocr/civilrights/understanding/disability/adamobilityimpairmentsguidance.pdf>.

²⁸ Stillman et al., *supra* note 5, at 504.

²⁹ Iezzoni et al., *supra* note 22, at 621.

³⁰ Nondiscrimination on the Basis of Disability by State and Local Governments and Places of Public Accommodation; Equipment and Furniture, 75 Fed. Reg. 43,452, 43,455–56 (July 26, 2010).

³¹ *Disability, Equipment Barriers, and Women’s Health*, *supra* note 19, at 25; Gardner-Bonneau & Isaacson Kailes, *supra* note 6.

depression, among many other health-related issues.³² To provide equitable health care services to patients who use a wheelchair, medical care providers should have a scale with a platform and weight capacity that can accommodate a person in a wheelchair.³³ Yet research indicates that physicians often do not weigh their patients who use a wheelchair because they failed to obtain an accessible scale.³⁴

In a 2017 survey of 432 adult wheelchair users, 57 percent reported that they “were not weighed by their primary care provider.”³⁵ Of that 57 percent, 82.5 percent reported their provider did not have a wheelchair-accessible scale.³⁶ More recently, a 2021 survey of 714 physicians practicing in the United States indicates that only 10 percent of participants always use an accessible scale, compared to 64.4 percent that never use an accessible scale.³⁷ Without change, physicians will continue to use inaccessible scales,³⁸ leading them to estimate medication dosages and miss important health indicators for their patients with physical disabilities.³⁹

C. Women’s Preventative Cancer Screening

“Women with disabilities are less likely to receive regular breast and cervical cancer screenings and are more likely to have cancer and then be diagnosed at a later stage, than women without disabilities.”⁴⁰ As discussed by Professor of Law Elizabeth Pendo, a major reason for these disparities is the lack of accessible medical equipment, such as mammogram machines that allow patients to remain seated while images are taken and height-adjustable examination tables with leg supports for conducting Pap tests.⁴¹

³² *Disability, Equipment Barriers, and Women’s Health*, *supra* note 19, at 25; NCD, ACCESSIBLE MEDICAL EQUIPMENT, *supra* note 1, at 18.

³³ DOJ & HHS, ACCESS TO MEDICAL CARE, *supra* note 27, at 18.

³⁴ Nondiscrimination on the Basis of Disability by State and Local Governments and Places of Public Accommodation; Equipment and Furniture, 75 Fed. Reg. at 43,455.

³⁵ Stillman et al., *supra* note 5, at 504.

³⁶ *Id.*

³⁷ Iezzoni et al., *supra* note 22, at 620.

³⁸ See NCD, ACCESSIBLE MEDICAL EQUIPMENT, *supra* note 1, at 8.

³⁹ See Gardner-Bonneau & Isaacson Kailes, *supra* note 6; see also *Disability, Equipment Barriers, and Women’s Health*, *supra* note 19, at 25.

⁴⁰ CTRS. FOR MEDICARE & MEDICAID SERVS., OFF. OF MINORITY HEALTH, PAVING THE WAY TO EQUITY: A PROGRESS REPORT 6 (2021).

⁴¹ See *Disability, Equipment Barriers, and Women’s Health*, *supra* note 19, at 24.

A mammogram is an x-ray of the breast tissue used to detect irregularities that cannot be detected through a self-examination or a manual examination by a doctor.⁴² “Early detection of breast cancer through screening mammography is associated with a reduction in breast cancer deaths among women ages 40–69 years.”⁴³ Accordingly, the American Cancer Society recommends that women between the ages of forty-five and fifty-four get a mammogram every year.⁴⁴ To conduct a mammogram, the patient must stand in front of an imaging machine while their breasts are flattened between two plates, allowing for an accurate image of the breast tissue.⁴⁵ The patient is typically required to remain standing while several images are taken, which can be difficult or impossible for individuals who have a physical disability.⁴⁶ To accommodate such patients, health care providers should use mammogram machines that are height-adjustable, allowing the patient to remain seated while the images are taken.⁴⁷

“Cervical cancer was the fourth most common cancer in women in 2020”⁴⁸ Yet “cervical cancer is almost completely preventable” with the early detection of precancerous cells through cervical cancer tests, such as a Pap smear.⁴⁹ Accordingly, the National Cancer Institute recommends that women receive a Pap test every three years.⁵⁰ Conducting a cervical cancer test requires that the patient lay on an examination table with their legs elevated so that the physician has

⁴² *Id.* at 26.

⁴³ NCD, ACCESSIBLE MEDICAL EQUIPMENT, *supra* note 1, at 18.

⁴⁴ AM. CANCER SOC’Y, AMERICAN CANCER SOCIETY GUIDELINES FOR THE EARLY DETECTION OF CANCER 1 (2023), <https://www.cancer.org/healthy/find-cancer-early/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html>.

⁴⁵ Elizabeth Pendo, *Reducing Disparities Through Health Care Reform: Disability and Accessible Medical Equipment*, 4 UTAH L. REV. 1057, 1065 (2010) [hereinafter *Reducing Disparities*]; *What Is a Mammogram?*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 26, 2022), https://www.cdc.gov/cancer/breast/basic_info/mammograms.htm#:~:text=A%20mammogram%20is%20an%20X,before%20it%20can%20be%20felt.

⁴⁶ *Reducing Disparities*, *supra* note 45; see also Nicole D. Agaronnik et al., *Implications of Physical Access Barriers for Breast Cancer Diagnosis and Treatment in Women with Mobility Disability*, 33 J. DISABILITY POL’Y STUD. 46, 48 (2022).

⁴⁷ DOJ & HHS, ACCESS TO MEDICAL CARE, *supra* note 27, at 17.

⁴⁸ Jin Young Choi et al., *Disparities in the Diagnosis, Treatment, and Survival Rate of Cervical Cancer Among Women With and Without Disabilities*, 28 CANCER CONTROL 1,1 (2021).

⁴⁹ *Id.*

⁵⁰ See *Cervical Cancer Screening*, NAT’L CANCER INST. (Oct. 13, 2022), <https://www.cancer.gov/types/cervical/screening>.

proper access to the patient's cervix to conduct the examination.⁵¹ Thus, medical care providers should acquire height-adjustable examination tables with adjustable, padded leg supports to provide patients with physical disabilities the same benefit of preventative screening that they provide to nondisabled patients.⁵²

III. THE FEDERAL LAWS THAT MANDATE EQUITABLE HEALTH CARE ARE UNDERENFORCED

The lack of accessible medical equipment advances inequities in health care between patients that have a disability and those that do not, despite federal legislation prohibiting such discriminatory outcomes. The ADA and Section 504 of the Rehabilitation Act are the two principal federal civil rights laws that intend to promote accessible health care for individuals with disabilities.⁵³ Both laws prohibit discrimination by health care providers on the basis of a patient's disability and require that such patients receive "full and equal access to their health care services and facilities."⁵⁴

Section 504 prohibits any program that receives federal funding from discriminating against an individual on the basis of the individual's disability.⁵⁵ Accordingly, health care facilities "that accept Medicaid funds, Medicare funds, or any other form of federal funding must ensure equal access to programs and services" for patients with disabilities.⁵⁶ Title II of the ADA "extends the prohibition on discrimination established by section 504 of the Rehabilitation Act of 1973 . . . to all activities of State and local governments regardless of

⁵¹ See *id.*; see also *Disability, Equipment Barriers, and Women's Health*, *supra* note 19, at 23.

⁵² *Disability, Equipment Barriers, and Women's Health*, *supra* note 19, at 24–25; DOJ & HHS, ACCESS TO MEDICAL CARE, *supra* note 27, at 8.

⁵³ Elizabeth Pendo, *The Costs of Uncertainty: The DOJ's Stalled Progress on Accessible Medical Equipment Under the Americans with Disabilities Act*, 12 ST. LOUIS U. J. HEALTH L. & POL'Y 351, 353 (2019) [hereinafter *The Costs of Uncertainty*].

⁵⁴ DOJ & HHS, ACCESS TO MEDICAL CARE, *supra* note 27, at 1.

⁵⁵ 29 U.S.C. § 794(a); AM. MED. ASS'N, ACCESS TO CARE FOR PATIENTS WITH DISABILITIES: STRATEGIES FOR ENSURING A SAFE, ACCESSIBLE AND ADA COMPLIANT PRACTICE 1 (2018).

⁵⁶ *Disability, Equipment Barriers, and Women's Health*, *supra* note 19, at 30; Haley Moss, "I'm Tired of Waiting": Diagnosing Accessibility Issues and Inequality for Patients with Disabilities Within the American Healthcare System, 51 U. MEM. L. REV. 1011, 1023 (2021).

whether these entities receive Federal financial assistance.”⁵⁷ This includes public hospitals and physicians’ offices that are operated by State and local governments.⁵⁸ “Title II sets not only a nondiscrimination standard but also an ‘equality of opportunity’ requirement in publicly operated settings.”⁵⁹ Accordingly, public health care facilities may not provide patients with disabilities services that are “not as effective in affording equal opportunity to obtain the same result [or] gain the same benefit . . . as that provided to others.”⁶⁰

Title III of the ADA further extends the prohibition on discrimination on the basis of an individual’s disability to places of public accommodation.⁶¹ A place of public accommodation is “a facility operated by a private entity whose operations affect commerce and fall within at least one of” the specifically listed categories, which includes hospitals and the offices of health care providers.⁶² Private health care providers covered under Title III must “provide equal services to individuals with disabilities . . . [and] make reasonable modifications in policies and practices where necessary to provide equal access,”⁶³ unless doing so would “fundamentally alter the nature of the” services that they offer.⁶⁴

Mostly all medical care providers fall under at least one of these laws that require equal health care services for patients with disabilities.⁶⁵ So why does ableism within the health care system continue to exist decades after the passing of these laws? Although Section 504 and the ADA require that health care facilities offer equitable services to their patients with disabilities, these laws have not effectively addressed health care disparities.⁶⁶ Many stakeholders

⁵⁷ *State and Local Governments (Title II)*, U.S. DEP’T. OF JUST. C.R. DIV., https://archive.ada.gov/ada_title_II.htm (last visited Apr. 8, 2023); *Disability, Equipment Barriers, and Women’s Health*, *supra* note 19, at 30.

⁵⁸ DOJ & HHS, ACCESS TO MEDICAL CARE, *supra* note 27, at 1.

⁵⁹ Sara Rosenbaum, *The Americans with Disabilities Act in a Health Care Context*, in INST. OF MED. OF THE NAT’L ACADS., THE FUTURE OF DISABILITY IN AMERICA app. D, at 430 (Marilyn J. Field & Alan M. Jette eds., 2007).

⁶⁰ 28 C.F.R. § 35.130(b)(1)(iii) (2022).

⁶¹ Rosenbaum, *supra* note 59.

⁶² See 28 C.F.R. § 36.104 (2022); 42 U.S.C. § 12181(7)(F).

⁶³ CMS, INCREASING PHYSICAL ACCESSIBILITY, *supra* note 4.

⁶⁴ § 36.302(a).

⁶⁵ Blake, *supra* note 16, at 794–95.

⁶⁶ Robyn M. Powell, *Applying the Health Justice Framework to Address Health and Health Care Inequities Experienced by People with Disabilities During and After COVID-19*, 96 WASH.

suggest that this ineffectiveness is due to the underenforcement of these laws.⁶⁷

One potential reason for this underenforcement is that enforcement of the ADA “generally rel[ies] upon the violation of a single individual’s rights, or in the case of a class action, the rights of a legally and factually similarly situated group.”⁶⁸ Although an individual who receives inadequate health care services due to their disability may bring a private action against their health care provider, many do not want to go through the hassle and expense of bringing a lawsuit.⁶⁹ Additionally, some patients may refrain from filing a lawsuit against their health care providers due to fear of reprisal⁷⁰ or fear of losing their health care providers.⁷¹ Even when such lawsuits are successful, relief is confined to the specific facility at issue. Thus, this case-by-case approach has failed to lead to any widespread change.⁷²

Another reason this issue persists despite the existence of these laws is that neither Section 504 nor the ADA identifies clear standards for what accessible equipment is necessary for compliance.⁷³ The closest thing that medical providers currently have for guidance regarding what accessible equipment they should have in their facility is the United States Access Board’s Standards for Accessible Medical Diagnostic Equipment, which became effective on February 8, 2017.⁷⁴ These standards set forth minimum criteria for accessible medical equipment for “physician’s offices, clinics, emergency rooms, hospitals, and other medical settings”⁷⁵ and provide guidelines for obtaining accessible “examination tables, examination chairs, weight scales, mammography equipment, and other imaging equipment” used by health care providers.⁷⁶ Yet the Access Board is not given

L. REV. 93, 104 (2021) (quoting Anne Ordway et al., *Health Care Access and the Americans with Disabilities Act: A Mixed Methods Study*, 14 DISABILITY & HEALTH J. 1, 1 (2021)).

⁶⁷ *Id.* at 104 n.70; OFF. OF DISEASE PREVENTION & HEALTH PROMOTION, *supra* note 12 (“Governmental agencies, advocacy organizations, academic researchers, and others have documented that the ADA and Rehabilitation Act are underenforced.”).

⁶⁸ Silvia Yee et al., *Achieving Accessible Health Care for People with Disabilities: Why the ADA Is Only Part of the Solution*, 3 DISABILITY & HEALTH J. 253, 256 (2010).

⁶⁹ *See id.* at 255.

⁷⁰ *Id.*

⁷¹ NCD, ACCESSIBLE MEDICAL EQUIPMENT, *supra* note 1, at 36.

⁷² *Id.*

⁷³ *See Disability, Equipment Barriers, and Women’s Health*, *supra* note 19, at 37.

⁷⁴ *The Costs of Uncertainty*, *supra* note 53, at 357.

⁷⁵ 29 U.S.C. § 794f(a).

⁷⁶ CMS, INCREASING PHYSICAL ACCESSIBILITY, *supra* note 4, at 4.

authority to enforce these standards.⁷⁷ Rather, these standards are “not mandatory on health care providers [or] equipment manufacturers,”⁷⁸ and compliance is not required unless another federal agency adopts them as mandatory for the entities within its jurisdiction.⁷⁹

So far, the only federal agency that has adopted these standards is the Department of Veterans’ Affairs (VA), which requires that any new equipment purchased by its health care providers meet the accessibility standards set forth by the Access Board.⁸⁰ The VA’s stated purpose for adopting these standards is to “help it meet [its] responsibilities under section 504 of the Rehabilitation Act which requires access to federally funded programs and services.”⁸¹ Although this is a step in the right direction, further action is necessary to provide all Americans with disabilities health care services that are equal to those received by able-bodied Americans.

The prevalence of inaccessibility within the health care system decades after the passing of Section 504 and the ADA indicates that “health care providers are unlikely to alter their practices and acquire accessible medical equipment” without any change in the way these laws are enforced.⁸² Because Medicare and Medicaid programs provide health care services to many Americans with disabilities, these programs are appropriate catalysts for solving the issue of inaccessible health care.

IV. HOW MEDICARE HAS BEEN USED TO ENFORCE CIVIL RIGHTS LAWS

Medicare is a federal health insurance program that provides coverage for persons ages sixty-five and older, younger persons with certain disabilities, and persons with certain end-of-life diseases.⁸³ The

⁷⁷ Standards for Accessible Medical Diagnostic Equipment, 82 Fed. Reg. 2810, 2810 (Jan. 9, 2017).

⁷⁸ *About the Accessibility Standards for Medical Diagnostic Equipment*, U.S. ACCESS BD., <https://www.access-board.gov/mde> (last visited Apr. 8, 2023).

⁷⁹ Standards for Accessible Medical Diagnostic Equipment, 82 Fed. Reg. at 2810.

⁸⁰ CMS, INCREASING PHYSICAL ACCESSIBILITY, *supra* note 4, at 4.

⁸¹ *VA Adopts New Standards for Medical Diagnostic Equipment*, U.S. ACCESS BD. (Apr. 20, 2017, 3:15 PM), <https://content.govdelivery.com/accounts/USACCESS/bulletins/19450a9>.

⁸² See NCD, ACCESSIBLE MEDICAL EQUIPMENT, *supra* note 1, at 8.

⁸³ *What’s Medicare?*, MEDICARE.GOV, <https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare> (last visited Apr. 8, 2023).

Medicare program is divided into “Parts.”⁸⁴ Part A, known as “hospital insurance,” helps pay for inpatient hospital care and limited stays in a skilled nursing facility.⁸⁵ Part B, “medical insurance,” covers doctor’s visits, durable medical equipment, outpatient care, mental health services, and home health care services.⁸⁶ Part D provides payment for prescription drugs.⁸⁷ A Medicare Advantage Plan, previously known as Part C, allows beneficiaries who are eligible for “Original Medicare” to bundle their Part A, Part B, and Part D coverage into one plan through a private insurance company, usually for additional benefits.⁸⁸

Individuals ages sixty-five and older who receive Social Security or Railroad Retirement benefits, as well as individuals under the age of sixty-five who have received Social Security Disability benefits for at least two years, are automatically enrolled in Medicare Part A.⁸⁹ Anyone who is eligible to receive Medicare Part A at no cost may also “enroll in Medicare Part B by paying a monthly premium.”⁹⁰ Persons ages sixty-five and older not yet receiving these retirement benefits may enroll by filing an application.⁹¹

Providers that deliver care to Medicare beneficiaries are paid through two trust accounts that are held by the United States Treasury.⁹² The “Hospital Insurance (HI) Trust Fund,” which pays Part A providers, is funded primarily through taxes on Social Security Benefits, interest earned on the trust account, and premiums paid by beneficiaries.⁹³ The “Supplemental Medical Insurance (SMI) Trust Fund,” which pays Part B and Part D providers, is funded primarily through “funds authorized by Congress” and beneficiary premiums.⁹⁴

⁸⁴ See SOC. SEC. ADMIN., MEDICARE 2 (2023), <https://www.ssa.gov/pubs/EN-05-10043.pdf>.

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.* at 2, 11. “Original Medicare” refers to those who “receive . . . Part A and Part B benefits directly from the government.” *Id.* at 5.

⁸⁹ *Id.* at 3–4.

⁹⁰ SOC. SEC. ADMIN., *supra* note 84, at 4.

⁹¹ See *id.* at 10.

⁹² See *How Is Medicare Funded?*, MEDICARE.GOV, <https://www.medicare.gov/about-us/how-is-medicare-funded> (last visited Apr. 8, 2023).

⁹³ *Id.*

⁹⁴ *Id.* Because the Medicare Advantage program includes Part A, Part B, and usually Part D benefits, the program is not separately funded. See Juliette Cubanski & Tricia Neuman, *FAQs on Medicare Financing and Trust Fund Solvency*, KAISER FAM. FOUND. (June 17, 2022), <https://www.kff.org/medicare/issue-brief/faqs-on-medicare->

Providers are reimbursed for the services they provide to Medicare beneficiaries based on “payment rates and systems that are specific to each type of provider.”⁹⁵ Part A providers are reimbursed on a prospective payment system, under which they receive a predetermined amount for each service they provide.⁹⁶ Participating physician offices are paid on a resource-based relative value scale (RBRVS), under which reimbursement is based on the cost of the service provided with adjustments for provider expenses, such as malpractice insurance.⁹⁷

Due to the federal government’s power to condition the receipt of Medicare funds, “Medicare has become the primary vehicle to bring health care entities under compliance with civil rights laws.”⁹⁸ A notable example of this is the use of Medicare funding for hospitals to enforce Title VI of the Civil Rights Act and fight racism within the American health care system.⁹⁹ Title VI of the Civil Rights Act prohibits discrimination on the basis of an individual’s race or ethnicity by any program that receives federal financial assistance.¹⁰⁰ The Act states: “[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”¹⁰¹

Before the passing of the Civil Rights Act in 1964, many “health care providers openly discriminated against African Americans.”¹⁰²

financing-and-trust-fund-solvency. Rather, the funds for Part A providers in a Medicare Advantage plan are paid from the Hospital Insurance Trust Fund, and the Part B and Part D providers in Medicare Advantage plans are paid from the Supplemental Medical Insurance Trust Fund. *Id.*

⁹⁵ See Juliette Cubanski et al., *A Primer on Medicare: Key Facts About the Medicare Program and the People it Covers*, KAISER FAM. FOUND. (Mar. 20, 2015), <https://www.kff.org/report-section/a-primer-on-medicare-how-does-medicare-pay-providers-in-traditional-medicare>.

⁹⁶ See *id.*; see also *Prospective Payment Systems – General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 1, 2021, 8:00 PM), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen>.

⁹⁷ Cubanski et al., *supra* note 95; see also 42 C.F.R. § 414.22 (2022).

⁹⁸ Blake, *supra* note 16, at 788.

⁹⁹ See Barton Smith, *supra* note 18, at 49–50.

¹⁰⁰ Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOWARD L.J. 855, 861 (2012).

¹⁰¹ 42 U.S.C. § 2000d.

¹⁰² Watson, *supra* note 100, at 860.

Some doctors refused to see African American patients altogether.¹⁰³ Many hospitals confined their African American patients to separate, inferior wards.¹⁰⁴ Some hospitals went as far as labeling their equipment by race.¹⁰⁵ Even after Congress signed the Civil Rights Act into law, integration of the health care system was off to a slow start.¹⁰⁶ Within the first year of the Act's passing, hospitals made little progress towards a desegregated health care system—especially hospitals in the south.¹⁰⁷ This slow progress was due not only to race-based biases, but also the underenforcement of the Civil Rights Act and the lack of clear standards regarding what being Title VI compliant meant for health care providers.¹⁰⁸

The enactment of the Medicare and Medicaid programs in 1965 provided the government with the financial leverage necessary to enforce Title VI within the health care system.¹⁰⁹ Before Title VI became law, “little federal money flowed into health care.”¹¹⁰ But with the enactment of the Medicare program, health care providers could collect payment from the federal government for care they would previously provide to elderly and indigent patients without compensation.¹¹¹ This brought billions of federal dollars into health care facilities and made for large percentages of the hospitals' total revenues.¹¹² Recognizing the financial leverage this provided the federal government over health care providers, as well as the need for stronger enforcement of the Civil Rights Act in the health care system, the Johnson Administration made it clear that hospitals would not be eligible to receive Medicare funding unless they could prove that they were in compliance with Title VI.¹¹³

The first step in this process was the creation of clear guidelines for hospitals so they knew exactly what they needed to do to be

¹⁰³ *Id.*

¹⁰⁴ *Id.*; Barton Smith, *supra* note 18, at 35.

¹⁰⁵ Quadagno, *supra* note 17, at 69.

¹⁰⁶ Barton Smith, *supra* note 18, at 49.

¹⁰⁷ Quadagno, *supra* note 17, at 80.

¹⁰⁸ Barton Smith, *supra* note 18, at 49.

¹⁰⁹ *See id.*

¹¹⁰ Watson, *supra* note 100, at 864.

¹¹¹ Barton Smith, *supra* note 18, at 49.

¹¹² *Id.*

¹¹³ *See* Quadagno, *supra* note 17.

considered Title VI compliant.¹¹⁴ The Office of Equal Health Opportunity (OEHO), an agency created to ensure Title VI compliance within the Medicare program, made these guidelines.¹¹⁵ Once these guidelines were finalized, all hospital administrators were sent a letter informing them that they could not participate in the Medicare program unless they could prove that they did not discriminate based on race.¹¹⁶ To be compliant, hospitals had to demonstrate that they admitted patients without regard to their race, that patients were not segregated within the facility based on their race, and that all patients had “access to all portions of the facility and to all services without discrimination.”¹¹⁷

The next step in implementing this program was conducting on-site inspections of the prospective recipients of Medicare funds to ensure their Title VI compliance.¹¹⁸ Before these inspections took place, a staff of nearly five hundred people, including medical students, outside consultants, and employees assigned from other programs, such as the Social Security Administration and the Public Health Service, completed a civil rights training program to learn how to detect racial discrimination within health care facilities.¹¹⁹ The trainees then set out to the hospitals to conduct their inspections.¹²⁰ Most hospitals had made the necessary changes before their site visit and were certified to receive Medicare funding.¹²¹ If a hospital was not Title VI compliant upon inspection, it would receive a written report regarding its shortcomings.¹²² The OEHO would then work with the hospital to bring it into compliance.¹²³

In just four months, “private hospitals in the United States went from the nation’s most segregated private institutions to its most

¹¹⁴ D. Mark Anderson et al., *The Federal Effort to Desegregate Southern Hospitals and the Black-White Infant Mortality Gap* 5 (Nat’l Bureau of Econ. Rsch., Working Paper No. 27970, 2020).

¹¹⁵ Barton Smith, *supra* note 18, at 50.

¹¹⁶ Quadagno, *supra* note 17.

¹¹⁷ P. Preston Reynolds, *The Federal Government’s Use of Title VI and Medicare to Racially Integrate Hospitals in the United States, 1963 Through 1967*, 87 AM. J. PUB. HEALTH 1850, 1852 (1997).

¹¹⁸ *See id.* at 1854.

¹¹⁹ *See id.*; *see also* Quadagno, *supra* note 17.

¹²⁰ *See* Preston Reynolds, *supra* note 117, at 1854.

¹²¹ *Id.*

¹²² *Id.*

¹²³ *Id.* at 1856.

integrated.”¹²⁴ Hospitals removed the “whites only” signs, and merged the segregated waiting rooms, operation rooms, and beds.¹²⁵ Over 6,500 hospitals, 92 percent of American hospitals at the time, were integrated,¹²⁶ marking significant progress from the only 49 percent of hospitals that were Title VI compliant three months before the Medicare program began.¹²⁷ It has been suggested that “[a] similarly courageous and aggressive program today could undoubtedly do much to address the problem of disparities” in the current health care system.¹²⁸ This Comment argues that this program should be used to fight ableism in health care by addressing the lack of medical equipment that is accessible to individuals with disabilities.

V. USING MEDICARE AND MEDICAID TO FIGHT ABLEISM IN HEALTH CARE

Racism in the American health care system sanctioned inferior health care for patients of color. Although Title VI prohibited the segregation of hospitals that led to this inferior care, little progress toward integration occurred until the Johnson Administration’s aggressive enforcement of Title VI through the threat of withholding Medicare funding.¹²⁹ Today, we are faced with the similar problem of ableism in health care. Due to the use of equipment that is inaccessible to patients with a disability, patients with disabilities receive inadequate health care services and face poorer health care outcomes than able-

¹²⁴ Barton Smith, *supra* note 18, at 52.

¹²⁵ Watson, *supra* note 100, at 864.

¹²⁶ *Id.*

¹²⁷ Preston Reynolds, *supra* note 117, at 1853. While this Comment uses the desegregation of American hospitals as a promising model for the aggressive enforcement of civil rights laws in health care, it is important to note that the American health care system is by no means perfect when it comes to racial equality. For a discussion of how racism still plagues health care, see Rene Bowser, *Racial Bias in Medical Treatment*, 105 DICK. L. REV. 365 (2001); Dorothy E. Roberts, *The Most Shocking and Inhuman Inequality: Thinking Structurally about Poverty, Racism, and Health Inequities*, 49 U. MEM. L. REV. 167 (2018); Charlene Galarneau & Ruqaiyah Yearby, *Racism, Health Equity, and Crisis Standards of Care in the COVID-19 Pandemic*, 14 ST. LOUIS U.J. HEALTH L. & POL’Y 211 (2021).

¹²⁸ Timothy Stoltzfus Jost, *Racial and Ethnic Disparities in Medicare: What the Department of Health and Human Services and the Centers for Medicare and Medicaid Services Can, and Should, Do*, 9 DEPAUL J. HEALTH CARE L. 667, 671 (2005).

¹²⁹ See Barton Smith, *supra* note 18, at 49.

bodied Americans.¹³⁰ Although the ADA and Section 504 have prohibited these outcomes for decades, the problem persists due to the underenforcement of these laws and the lack of clear standards for what accessible medical equipment physicians need to be compliant with these laws.¹³¹ It has become clear that without more aggressive enforcement, these circumstances are not likely to change.¹³² This Comment argues that using the Johnson Administration's program for enforcing Title VI to enforce Section 504 and the ADA will provide the aggressive enforcement necessary to fight ableism in health care and provide individuals with disabilities equitable health care services.

The actions taken by the Johnson Administration to fight racism in health care at its most basic level boil down to four steps: (1) create clear guidelines for what constitutes compliance with civil rights laws, (2) inform providers that the continued receipt of federal funds is dependent upon their compliance with these laws, (3) inspect the providers' facilities to ensure that they have complied, and (4) withhold funding from facilities that fail to comply.¹³³ CMS, which oversees the Medicare and Medicaid programs,¹³⁴ should apply this framework to enforce Section 504 and the ADA by requiring that all Medicare and Medicaid providers obtain accessible medical equipment in order to participate in these programs.

A. *Medicare*

As recipients of federal financial assistance through the United States Department of Health and Human Services (DHHS), Medicare Part A providers are subject to Section 504 of the Rehabilitation Act.¹³⁵ Like Title VI, which states that “[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal

¹³⁰ See CTRS. FOR MEDICARE & MEDICAID SERVS., MODERNIZING HEALTH CARE TO IMPROVE PHYSICAL ACCESSIBILITY: A PRIMER FOR PROVIDERS 3 (2021) [hereinafter CMS, MODERNIZING HEALTH CARE].

¹³¹ See OFF. OF DISEASE PREVENTION & HEALTH PROMOTION, *supra* note 12; see also *Disability, Equipment Barriers, and Women's Health*, *supra* note 19, at 37.

¹³² See NCD, ACCESSIBLE MEDICAL EQUIPMENT, *supra* note 1, at 8.

¹³³ See Quadagno, *supra* note 17.

¹³⁴ See *How Is Medicare Funded?*, *supra* note 92.

¹³⁵ See 45 C.F.R. § 84.1 (2022) (“The purpose of this part is to effectuate section 504 of the Rehabilitation Act of 1973”); § 84.2 (“This part applies to each recipient of Federal financial assistance from the Department of Health and Human Services and to the program or activity that receives such assistance.”).

financial assistance,”¹³⁶ Section 504 requires that no person, by reason of disability, “be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”¹³⁷

In addition to Section 504, Medicare Part A providers are subject to the ADA. As mentioned above, Title II of the ADA extends the protections against discrimination offered by Section 504 “to all activities of State and local governments regardless of whether these entities receive Federal financial assistance.”¹³⁸ Thus, publicly operated Medicare providers are subject to Title II.¹³⁹ Additionally, privately operated providers are subject to Title III of the ADA, which prohibits discrimination on the basis of disability by places of public accommodation.¹⁴⁰ Because both Section 504 and the ADA apply to Medicare Part A providers, CMS may rely on the enforcement of both of these laws to require that they obtain accessible medical equipment.

“CMS has legal authority under Title XVIII of the Social Security Act to require health care providers to meet the legal requirements of the civil rights nondiscrimination statutes and regulations enforced by [Office for Civil Rights (OCR)] in order to participate in the Medicare Part A program.”¹⁴¹ Currently, CMS exercises this authority by requiring that all Part A providers receive civil rights clearance from the OCR to participate in the Medicare program.¹⁴² To do so, the provider must sign an Assurance of Compliance form, which confirms that they are in compliance with the civil rights laws enforced by the OCR, including Section 504 of the Rehabilitation Act.¹⁴³ This form states that “[t]he Applicant agrees that compliance with this assurance

¹³⁶ 42 U.S.C. § 2000d.

¹³⁷ 29 U.S.C. § 794(a); *see Alexander v. Choate*, 469 U.S. 287, 293 n.7 (1985) (recognizing that “[Section] 504 was modeled in part on Title VI”).

¹³⁸ *State and Local Governments (Title II)*, *supra* note 57.

¹³⁹ *See DOJ & HHS, ACCESS TO MEDICAL CARE*, *supra* note 27, at 1.

¹⁴⁰ *Id.*

¹⁴¹ *Civil Rights Clearance for Medicare Provider Applicants*, U.S. DEP’T. OF HEALTH & HUM. SERVS. (Oct. 26, 2021), <https://www.hhs.gov/civil-rights/for-providers/clearance-medicare-providers/index.html>. The OCR “is responsible for enforcing civil rights laws that apply to recipients of Federal financial assistance from the U.S. Department of Health and Human Services,” including Section 504 of the Rehabilitation Act. *Enforcement Activities and Results*, U.S. DEP’T. OF HEALTH & HUM. SERVS. (Oct. 27, 2021), <https://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/index.html>.

¹⁴² *Civil Rights Clearance for Medicare Provider Applicants*, *supra* note 141.

¹⁴³ *See id.*

constitutes a condition of continued receipt of Federal financial assistance.”¹⁴⁴ Accordingly, this agreement gives CMS authority to withhold Medicare funding from any Part A provider that fails to comply with Section 504. CMS should exercise this authority to enforce Section 504 and require that providers obtain accessible medical equipment to continue receiving federal funding.

CMS also has authority to “develop[] Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs.”¹⁴⁵ Currently all hospitals participating in the Medicare program “must be in compliance with applicable Federal laws related to the health and safety of patients.”¹⁴⁶ This arguably encompasses compliance with the ADA; however, CMS should consider explicitly requiring ADA compliance and thus the acquisition of accessible medical equipment as a condition of participation in the Medicare program for all providers. Upon any failure of a provider to comply with the conditions of participation, CMS has authority to terminate its agreement with that provider.¹⁴⁷ CMS should use this authority to enforce the ADA and require that providers obtain accessible medical equipment to continue participating, and thus receive funding through the Medicare program.

Applying the Johnson Administration’s framework for enforcing civil rights laws through the Medicare program, the first step will be to create guidelines regarding what medical equipment each provider must obtain. One factor recognized as contributing to the success of hospital desegregation under the Johnson Administration was that “the government’s civil rights demands were unambiguous Therefore, ‘hospitals understood what was expected of them’”¹⁴⁸ Accordingly, it is important that CMS provides clear standards for what is necessary to be Section 504 and ADA compliant. To do so, CMS

¹⁴⁴ U.S. DEP’T. OF HEALTH & HUM. SERVS., ASSURANCE OF COMPLIANCE, HHS FORM 690, <https://www.hhs.gov/sites/default/files/forms/hhs-690.pdf> (last visited Apr. 8, 2023).

¹⁴⁵ *Conditions for Coverage (CfCs) & Conditions of Participation (CoPs)*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 1, 2021, 7:02 PM), <https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs>.

¹⁴⁶ 42 C.F.R. § 482.11 (2022).

¹⁴⁷ *Id.* § 489.53(a)(3) (“CMS may terminate the agreement with any provider if CMS finds that . . . [i]t no longer meets the appropriate conditions of participation”).

¹⁴⁸ Watson, *supra* note 100, at 865 (quoting DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION 214–16 (1999)).

should adopt the Access Board's Accessibility Standards for Medical Diagnostic Equipment as mandatory for all Medicare providers.

As the adopting agency, CMS will need to "determine the application and scope of these standards,"¹⁴⁹ such as what equipment, and how much equipment, each provider will need. The Department of Justice suggests that "the number of accessible exam tables needed by the medical care provider depends on the size of the practice, the patient population, and other factors."¹⁵⁰ Although "[o]ne accessible exam table may be sufficient in a small doctor's practice . . . more will likely be necessary in a large clinic."¹⁵¹ Accordingly, most providers will not be required to replace all equipment—just enough that they can adequately serve their patients with disabilities. CMS must determine what equipment is necessary for Section 504 and ADA compliance and inform providers accordingly. CMS must also inform providers that the continued receipt of Medicare funding is dependent on their compliance with these guidelines.

After providers are given a reasonable amount of time to make the necessary changes to their facilities, CMS must conduct on-site inspections to assess provider compliance with the accessibility guidelines. Currently, state agencies conduct periodic inspections of providers' facilities "to ascertain whether a provider . . . meets [the] applicable requirements for participation in the Medicare and/or Medicaid programs, and to evaluate performance and effectiveness in rendering a safe and acceptable quality of care."¹⁵² Thus, CMS is already equipped to conduct on-site inspections. CMS and the OCR should train the state agency staff to inspect facilities for compliance with the accessibility standards and arrange for the inspection of all providers' facilities to ensure they have obtained the necessary accessible equipment.

Upon any finding of noncompliance, CMS should attempt to work with the provider and help them come into compliance; however, those that fail to comply after a fair amount of time and guidance were provided should not receive further Medicare funding until they

¹⁴⁹ Standards for Accessible Medical Diagnostic Equipment, 82 Fed. Reg. 2810, 2810 (Jan. 9, 2017).

¹⁵⁰ DOJ & HHS, ACCESS TO MEDICAL CARE, *supra* note 27, at 3.

¹⁵¹ *Id.*

¹⁵² CTRS. FOR MEDICARE & MEDICAID SERVS., CERTIFICATION PROCESS, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/downloads/CertandComplianceProcess.pdf> (last visited Apr. 8, 2023).

obtain the necessary accessible equipment. CMS should undertake similar procedures for future Medicare provider applicants. The CMS Regulations state that if a Part A provider does not “meet the applicable civil rights requirements of . . . Section 504 of the Rehabilitation Act of 1973,”¹⁵³ CMS will not enter into a provider agreement” with that facility.¹⁵⁴ The Regulations also state that to participate in the Medicare program, prospective providers must “[b]e in compliance with the applicable conditions,” including compliance with all applicable federal laws.¹⁵⁵ Accordingly, when a new facility applies to become a Medicare provider, it should be required to undergo an initial site inspection to ensure it has the appropriate accessible equipment. If the facility does not have the required equipment, the inspectors should determine that it does not meet the requirements of Section 504 and the ADA and is therefore not eligible to participate in the Medicare program.

It is important to note that there are some limitations with the above methods of enforcement. First, Medicare payments to Part B providers are not considered federal financial assistance for purposes of Section 504.¹⁵⁶ Part B providers are therefore not subject to Section 504 and are not required to submit an Assurance of Compliance form to participate in the Medicare program.¹⁵⁷ Yet research shows that the issue of inaccessible medical equipment is prevalent in physicians’ offices,¹⁵⁸ and therefore must be addressed in an equally aggressive manner. CMS can ensure that physicians receive the same aggressive enforcement under this program through two methods.

First, although Section 504 may not apply to all non-hospital providers, the ADA makes it clear that all health care facilities must

¹⁵³ 42 C.F.R. § 489.10(b)(2) (2022).

¹⁵⁴ § 489.12(c).

¹⁵⁵ *Id.* § 488.3(a)(2); *see also id.* § 482.11.

¹⁵⁶ Blake, *supra* note 16, at 794; *see* 45 C.F.R. pt. 84 app. A (2022) (“The Department’s position has consistently been that, whether or not Medicare Part B arrangements involve a contract of insurance or guaranty, no Federal financial assistance flows from the Department to the doctor or other practitioner under the program, since Medicare Part B—like other social security programs—is basically a program of payments to direct beneficiaries.”).

¹⁵⁷ *See Civil Rights Clearance for Medicare Provider Applicants*, *supra* note 141 (emphasis added) (explaining that only “Medicare Part A providers are required to sign an attestation of their compliance with all applicable civil rights laws enforced by OCR”).

¹⁵⁸ *See generally* Jennifer Pharr, *Accessible Medical Equipment for Patients with Disabilities in Primary Care Clinics: Why Is it Lacking?*, 6 DISABILITY & HEALTH J. 124 (2013); Fragala et al., *supra* note 23; Mudrick et al., *supra* note 22; Stillman et al., *supra* note 5.

provide equitable care to patients with disabilities, regardless of whether they receive federal financial assistance.¹⁵⁹ Therefore, CMS should also use the Johnson Administration's framework to enforce the ADA by requiring the acquisition of accessible medical equipment. CMS cannot achieve this using the above-mentioned method of enforcement through the conditions of participation because the conditions of participation do not apply to all providers.¹⁶⁰ Thus, CMS may consider creating conditions of participation that apply to all Medicare providers or enforcing the ADA through an alternative method that would reach both Part A and Part B providers. Second, although Medicare Part B providers are not considered recipients of federal financial assistance for purposes of Section 504,¹⁶¹ Medicaid providers are.¹⁶² Therefore, CMS should use the Johnson Administration's framework for civil rights enforcement to require that Medicaid beneficiaries with disabilities receive equitable care from their providers.

B. *Medicaid*

"Medicaid is a key source of insurance coverage for individuals with disability."¹⁶³ Although many Medicaid beneficiaries with disabilities are also covered under Medicare, it is estimated that an additional 6.2 million individuals with disabilities only have Medicaid coverage.¹⁶⁴ Therefore, the problem of inaccessible medical equipment is best solved if CMS also uses the Johnson Administration's method of enforcement to require that Medicaid providers obtain accessible medical equipment.

Medicaid "is a joint federal and state public health insurance program" that covers "low-income adults, children, pregnant women,

¹⁵⁹ See 42 U.S.C. § 12132; *id.* § 12181(7)(F) (listing "professional office of a health care provider" as a public accommodation subject to Title III).

¹⁶⁰ See *Conditions for Coverage (CfCs) & Conditions of Participation (CoPs)*, *supra* note 145 (listing the health care organizations that the conditions of participation apply to).

¹⁶¹ See Blake, *supra* note 16, at 794; *see also* 45 C.F.R. pt. 84 app. A (2022).

¹⁶² *What Qualifies as "Federal Financial Assistance" for Purposes of Civil Rights Complaints Handled by OCR?*, U.S. DEP'T. OF HEALTH & HUM. SERVS. (Nov. 19, 2015), <https://www.hhs.gov/civil-rights/for-individuals/faqs/what-qualifies-as-federal-financial-assistance/301/index.html> (listing "[h]ealth care providers participating in CHIP and Medicaid programs" as recipients of federal financial assistance from the U.S. Department of Health & Human Services).

¹⁶³ OFF. OF DISEASE PREVENTION & HEALTH PROMOTION, *supra* note 12, at 17.

¹⁶⁴ *Id.* at 43.

elderly adults, and people with disabilities.”¹⁶⁵ Federal law sets mandatory standards for eligibility, benefits, and administration, and states create and administer their own Medicaid programs within these federal guidelines.¹⁶⁶ CMS administers Medicaid at the federal level, and state Medicaid agencies supervise the administration of the Medicaid program in each state.¹⁶⁷ The federal and state governments jointly fund the Medicaid program.¹⁶⁸ “The federal government pays states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP).”¹⁶⁹ The state pays the remainder, referred to as the “state share.”¹⁷⁰ FMAP rates have a statutory minimum of 50 percent and a statutory maximum of 83 percent of program expenditures.¹⁷¹

Due to this FMAP, Medicaid providers are considered recipients of federal financial assistance and are therefore subject to Section 504 of the Rehabilitation Act.¹⁷² The CMS State Operations Manual explains that “[a]s with Medicare, determinations of civil rights compliance of providers are . . . preconditions to approving the provider’s participation in the Medicaid program.”¹⁷³ Thus, providers must be Section 504 compliant to participate in the Medicaid program.¹⁷⁴ Each state Medicaid agency, rather than the federal government, is responsible for ensuring provider compliance with Section 504.¹⁷⁵ Therefore, CMS should require that each state

¹⁶⁵ *Id.* at 17 (quoting *Medicaid*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/index.html> (last visited Apr. 8, 2023)).

¹⁶⁶ *Id.*

¹⁶⁷ *Administration*, MACPAC, <https://www.macpac.gov/medicaid-101/administration> (last visited Apr. 8, 2023).

¹⁶⁸ *See Financial Management*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/financial-management/index.html> (last visited Apr. 8, 2023).

¹⁶⁹ *Id.*

¹⁷⁰ ALISON MITCHELL, CONG. RSCH. SERV., R43847, MEDICAID’S FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) (2020).

¹⁷¹ *Id.* at 2.

¹⁷² *See What Qualifies as “Federal Financial Assistance” for Purposes of Civil Rights Complaints Handled by OCR?*, *supra* note 162; 42 C.F.R. § 430.2 (2022) (explaining that the HHS Regulations that effectuate Section 504 apply to State Medicaid programs); 45 C.F.R. pt. 84 app. A (2022) (explaining that most Medicaid providers are regarded as recipients of federal financial assistance for purposes of Section 504).

¹⁷³ CTRS. FOR MEDICARE & MEDICAID SERVS., STATE OPERATIONS MANUAL § 1008C, PUB. NO. 100-07 8 (2004).

¹⁷⁴ *See id.*

¹⁷⁵ *Id.* (“Regarding Medicaid-only providers, the States themselves are considered the direct recipients of the Federal funds and may be considered to have a direct

Medicaid agency enforce Section 504 against its Medicaid providers by requiring that they obtain accessible medical equipment using the Johnson Administration's method for civil rights enforcement.

Additionally, as part of a program operated by the state government, Medicaid providers are subject to Title II of the ADA.¹⁷⁶ Any providers that are privately operated will also be subject to Title III of the ADA.¹⁷⁷ Accordingly, CMS may include ADA compliance through acquisition of accessible medical equipment as a condition of participation in the Medicaid program.¹⁷⁸ To provide the necessary financial pressure, the state's receipt of the FMAP should be conditioned on the state agency's enforcement of Section 504 and the ADA against their providers.¹⁷⁹

First, CMS should require that all state Medicaid agencies adopt the Access Board's Accessibility Standards for Medical Diagnostic Equipment and determine the appropriate amount of accessible equipment each facility must obtain. Next, the state agencies should inform their individual providers that they must obtain the accessible equipment appropriate for their facility to continue participating in the Medicaid program. CMS should then require that all state agencies conduct site inspections of their Medicaid providers to ensure their compliance with this policy. The Regulations for state Medicaid agencies explain that the states "[m]ust require any enrolled provider to permit CMS, its agents, its designated contractors, or the state

obligation to assure OCR of their compliance by assuring that funds go to providers who are in compliance.") (emphasis removed); 45 C.F.R. pt. 84 app. A (2022) ("[T]he Office for Civil Rights will concentrate its compliance efforts on the state Medicaid agencies and will look primarily to them to ensure compliance by individual providers.").

¹⁷⁶ See 42 U.S.C. § 12131(1)(A)–(B) (prohibiting discrimination on the basis of disability by "any State or local government" and "any department, agency, special purpose district, or other instrumentality of a State or States or local government").

¹⁷⁷ See *id.* § 12181(7)(F) (listing private hospitals and offices of health care providers as places of public accommodation).

¹⁷⁸ See *Conditions for Coverage (CfCs) & Conditions of Participation (CoPs)*, *supra* note 145 ("CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the . . . Medicaid program[.]").

¹⁷⁹ See 42 C.F.R. § 430.35(d) (2022). The United States Supreme Court has previously demonstrated reluctance to condition the receipt of Medicaid funds on state agency compliance with new federal guidelines. See *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 581–85 (2012). This suggestion is arguably distinguishable as the enforcement of existing guidelines. Nevertheless, an analysis of the constitutionality of this suggestion is beyond the scope of this Comment.

Medicaid agency to conduct unannounced on-site inspections of any and all provider locations.”¹⁸⁰ Therefore, such inspections are authorized. If the inspection indicates that the provider does not have the required accessible equipment, the agency should determine that the provider is not in compliance with the applicable civil rights laws and terminate their contract with the provider.

CMS should undertake a similar process for new Medicaid provider applicants. Before contracting with a new Medicaid provider, the state Medicaid agency should require a pre-enrollment inspection of the provider’s facility. If the provider does not have the accessible medical equipment appropriate for their facility, the provider should not be able to participate in the Medicaid program.

Understandably, the financial barriers to obtaining accessible equipment may deter providers from doing so.¹⁸¹ For example, a standard examination table costs between \$500 and \$850, while an examination table that is adjustable in height can cost between \$1,800 and \$2,100.¹⁸² Nonetheless, there are tax incentives that help offset the costs of improving facility accessibility.¹⁸³ At the federal level, there is Section 44 of the Internal Revenue Service (IRS) Code,¹⁸⁴ known as the Disabled Access Tax Credit for small businesses, which “allows for a credit of up to 50% of the amount of a business’s yearly eligible expenditures” to offset the costs of improving accessibility.¹⁸⁵ Also at the federal level is Section 190 of the IRS Code,¹⁸⁶ known as the Architectural Barrier Removal Tax Deduction, which is available to businesses of all sizes to offset the costs of removing accessibility barriers for up to \$15,000 a year.¹⁸⁷ Additional incentives may be available at the state level as well.¹⁸⁸ Although these incentives will not be applicable to non-profit hospitals that are tax exempt under

¹⁸⁰ *Id.* § 455.432(b).

¹⁸¹ CMS, INCREASING PHYSICAL ACCESSIBILITY, *supra* note 4, at 8.

¹⁸² Nicole Agaronnik et al., *Accessibility of Medical Diagnostic Equipment for Patients with Disability: Observations from Physicians*, 100 ARCHIVES PHYSICAL MED. & REHAB. 2032, 2037 (2019).

¹⁸³ *See* CMS, INCREASING PHYSICAL ACCESSIBILITY, *supra* note 4, at 8.

¹⁸⁴ *IRS Tax Credits and Deductions*, ADA.GOV, <https://www.ada.gov/taxcred.htm> (last visited Apr. 8, 2023).

¹⁸⁵ CMS, MODERNIZING HEALTH CARE, *supra* note 130, at 22.

¹⁸⁶ *IRS Tax Credits and Deductions*, *supra* note 184.

¹⁸⁷ CMS, MODERNIZING HEALTH CARE, *supra* note 130, at 22.

¹⁸⁸ CMS, INCREASING PHYSICAL ACCESSIBILITY, *supra* note 4, at 8.

Internal Revenue Code Section 501(c)(3),¹⁸⁹ they will be largely beneficial to all for-profit providers in mitigating any financial barriers to accessibility.

VI. CONCLUSION

Americans with disabilities face various disparities in the health care system, leading to poorer health outcomes in comparison to able-bodied Americans and negative impacts on their overall quality of life.¹⁹⁰ With the use of medical equipment, such as examination tables, scales, and imaging equipment, that is accessible to patients with a physical disability, these disparities could be reduced. Despite the existence of federal laws that require equitable health care services for patients with a disability,¹⁹¹ research shows that most health care providers have failed to obtain such equipment.¹⁹² The persistence of this issue in the face of these laws shows that stronger enforcement is needed to solve this problem. Because of the large number of individuals with disabilities receiving health insurance through the Medicare and Medicaid programs,¹⁹³ these programs are appropriate catalysts for enforcing these antidiscrimination laws and fighting ableism in the health care system. This will benefit not only beneficiaries of Medicare and Medicaid, but all patients of the health care providers participating in these programs. Aggressively enforcing Section 504 of the Rehabilitation Act and the ADA by requiring that providers obtain accessible medical equipment to continue participating in the Medicare and Medicaid programs will help reduce health care disparities between able-bodied patients and patients with physical disabilities.

¹⁸⁹ See *Charitable Hospitals – General Requirements for Tax-Exemption Under Section 501(c)(3)*, IRS (July 15, 2022), <https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3>.

¹⁹⁰ NCD, ACCESSIBLE MEDICAL EQUIPMENT, *supra* note 1, at 7.

¹⁹¹ See 29 U.S.C. § 794(a); 42 U.S.C. § 12132(a); *id.* § 12182(a).

¹⁹² See discussion *supra* Part II.

¹⁹³ See, e.g., CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 14, at 15; see also *Distribution of Medicare Beneficiaries by Eligibility Category*, *supra* note 14.