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01.15.16

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Comments Regarding Pending Mergers of: Centene-Health Net, Aetna-Humana, Anthem-Signa, Blue Shield-Care 1st Health Plan

Dear Mr. Tomashoff:

This letter represents my personal views. I am a Disability Policy Consultant and the Associate Director and Adjunct Associate Professor at Harris Family Center for Disability and Health Policy. I work as an advocate and as a contractor with a variety of health facilities, managed care plans, government projects and consulting firms. These projects include work with Rehabilitation Research and Training Centers: on Aging with a Disability, Managed Care and Disability, Health and Wellness and Disability, National Center of Physical Activity and Disability and the Rehabilitation Engineering Research Center on Accessible Medical Instrumentation, and the served on the Access Board's Medical Diagnostic Equipment Advisory Committee. I provide workshops on developing practical and actionable disability competencies in health care covering the demographics of disability populations (prevalence, causes, function versus diagnosis, employment rates, and health disparities) compliance with the Americans with Disabilities Act (attitudinal, communication, physical, medical equipment and programmatic access), care coordination and long term support services, and stakeholder engagement. More information is available at http://www.jik.com.

As the wave of proposed health plan consolidations is carefully reviewed for approval by California, I urge the California Department of Insurance to take advantage of this unique opportunity to strengthen and improve health care for people with disabilities and others with access and functional needs.

The documented gaps in network adequacy significantly impact **people with disabilities and others with access and functional needs** and contributes to

substandard and unequal treatment. (The **bolded terms** are defined in the paragraphs that follow these recommendations.)

Health disparities linked to race, ethnicity, language and disability status are deeply imbedded in our healthcare system. The requirement for provider networks standards to address the inaccessible status quo among providers is a change that is very important to the disability community. The majority of people with disabilities and others with access and functional needs are covered under commercial plans and not as commonly believed covered under public insurance.

Recommendations:

All merger approved health plans must:

1. Provide funds to carefully selected network provider sites, (primary care, specialty providers, FQHCs, clinics, and urgent care) to improve access to medical equipment through the purchase accessible examination equipment, communication devices and Video Remote Interpretation as well as mandating "effective use and disability competency" training for the recipients of this equipment regarding. Sites would be identified at strategic locations throughout the network service area to maximize access for members thus improving network adequacy. (See **Promising Practices** below)

2. The development of a statewide centralized database that captures accurate information regarding the **physical, communication and program access elements** for the purpose of creating a single portal that can be accessed by all plans members, member services, care coordinators and case managers. The database must be interoperable with any and all centralized data for provider directories.

3. The development of specific tools to evaluate the **physical, communication and program access elements** of hospitals.

4. Development of strategies to identify and integrate key disability **physical, communication and program access** elements into network capacity by:

    Establishing a statewide taskforce consisting of representatives from key associations of providers, community clinics, medical groups and IPAs, hospitals, health plans, and representatives from disability access groups as well as DMHC, and DHCS). Anticipated outcomes would include but not be limited to:

    A. Develop and / or identify educational tools and materials explaining for disability access compliance requirements, history of disability access and the Americans with Disabilities Act requirements.

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B. Develop network adequacy definitions and standards that define and integrate physical and programmatic accessibility, including components and requirements for easily accessible statewide data base for health plans and beneficiaries to access.

C. Recommend options for fundable incentives to support network providers, the health plan, and community providers to improve network capacity.

D. Develop audit strategies to identify and address the physical communication and programmatic access gaps. This includes clear guidance and a recommended enforcement mechanism.

E. Develop regulation that mandate accurate physical and programmatic accessibility information regarding each provider be integrated (through clear and specific information via with well explained legends of accessibility codes) into provider directories including web site versions of these directories. This information must able be easily available to care coordinators and case managers.

F. Develop standards for corrective action plan for providers with problematic access. (Even small providers can make some affordable changes such as installing grab bars, providing a ramp, adding Braille and raised lettering to elevator signage, rearranging display racks, adding directional signage. Larger providers and clinical groups can afford to make changes over time and should be held accountable to do so.)

BACKGROUND AND PROBLEM:

Network Capacity:

Achieving network adequacy remains a challenge for many health plans and managed care organizations (MCOs). Medicaid enrollment
California

Current California law governing managed care plans /// amber has specific geographic distance and time requirements that must be met for a plan's provider network to be considered adequate. These regulations do not take into account physical and programmatic accessibility needs.

For example, there may be 15 gynecologists in a provider network who are within allowable distance and time requirements of a member who is a wheelchair user, but if few or none of these gynecologists have height-adjustable exam tables, lifts, or available trained personnel to assist with a transfers, none of the providers can provide the member with an effective examination.

Existing time and distance standards do not take into account lengthy public transportation needs in dense urban areas such as Los Angeles, when public transportation is often the only viable form of transportation for many people with mobility, vision, and other disabilities, nor do the account for lengthy commute times of rural areas.

The MCO's data, presented in Los Angeles on 01.7.16 FSR training, from health plans with public projects using the **PARS** [[(Attachment C, Physical-Accessibility Reviews Survey(PARs) which is approximately 1 hour part of the 6-7 hour the Facility Site Reviews (FSR) conducted by plans)]] surveys continue to show a significant and widespread lack of accessible providers (Data). These findings are in sync with earlier research published by Mudrick, Nancy R.; Breslin, Mary Lou; Liang, Mengke; and Yee, Silvia, "Accessibility of Primary Health Care Settings for People with Disabilities" (2010). *School of Social Work.* These findings:

- Looked a combined data from 5 California plans address this gap with data on 2400 primary care provider facilities.
- Found 22 accessible weight scale was present in 3.6% and 23 a height adjustable examination tables were available in 8.4% of the sites
- Other high prevalence access barriers were in bathrooms & examination rooms.

People with disabilities and others with access and functional needs:

The requirement that health plans must provide access to health care services for people with disabilities and others with access and functional needs including preventive care and needed health services see https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/DisabilityAccess.aspx#.VpEviodIiot) continues to be problematic and not met for a large group of people.

The numbers of people who need an access related to communication, building, equipment and program and services are large across all lines of business and represent the vast majority of patients under Medi-Cal SPDs, Cal MediConnect and Medicare senior products. This large population includes: those with limited hearing, seeing, reading, or speaking abilities as well as those who use mobility devices such as wheelchairs, scooters, walkers, canes, crutches and those with limited ability to walk and use steps.

The invisibility of people with disabilities and others with access and functional needs is very common. These populations are typically under recognized and very under counted. ~~& are far greater in numbers than those coded as seniors and people with disabilities (SPD) and aged, blind and disabled (ABD).///~~

Substandard and unequal treatment:

When people with disabilities and others with access and functional needs have to struggle to find access, some find the effort of pursuing care is just too exhausting, overwhelming and / or too degrading. This leads to postponing or avoiding care, resulting in a downward spiral of lack of care, delayed diagnosis, and worsening conditions leading to wider disparities, deteriorating health, that eventually requires more extensive and expensive health care and diminished opportunities for productive lives.

Substandard and unequal treatment put all at risk of missing critical signs of conditions needing attention and contribute to such disparities as poorer overall health and increase prevalence of diabetes, obesity, smoking, inactivity, stroke, heart disease and pain. This unequal treatment is commonly manifested when providers say “will just examine you from you wheelchair” (because a height adjustable table or transfer assistance is not provided), “will just skip that test because I know it is hard for you” (because they don’t know what referral could accommodate the individual) or “just guess your weight” (because there is no accessible scale for wheelchair users and those unable to step up) or “We can write notes back and forth” (because a ASL interpreter, Computer assisted real-time transcription, or an assistive listening system is not available).

Promising practices:

An infusion of funds via grant programs for public programs has proven to be effective. These programs include projects initiated by L.A. Care, IEHP, Health Net, San Francisco Health Plan, and Molina, (past and current efforts) that provide funds to carefully selected network provider sites (primary care, specialty providers, FQHCs, clinics, and urgent care sites) to improve access to medical equipment through the purchase accessible examination equipment, communication devices and Video Remote Interpretation as well as mandating “Effective use and disability competency” training for the recipients of this equipment. Sites are identified at strategic locations throughout the network service area to maximize access for members thus improving network adequacy. Site selections includes geo-coding and mapping of high volume providers and significant geographic gaps.

Formal outcome reports are not yet available, but funded project exit interviews reveal many positive observations and anecdotal stories regarding the effectives of these installations and improved patient care and safety as well as provide safety (especially focused on prevention of work place injuries.

Programmatic and communication access:

When health plans only consider addressing the needs of people with physical disabilities, they leave out a large segment of people with disabilities and others with access and functional needs. These population segments include those with limitations

in seeing, hearing, speaking, reading, remembering, understanding, cognitive and intellectual abilities, as well as people with limited language proficiency. Without attention to these issues large numbers of people are prevented from receiving, understanding and using health information.

Practices need to identify, document, update and provide communication accommodations including:

- Sign language interpreters
- Oral interpretation
- Assistive listening devices
- Computer assister real-time transcription
- Longer appointments - commonly needed when working with participants with intellectual, speech, or hearing disabilities
- Print materials in alternative formats:
  - Audio recording
  - Large print
  - Electronic text/CD/flash drive
  - Braille
- Telecommunication / Phone options to reach those with communication limitations:
  - Email
  - Text messaging
  - 711 relay services: TTY, Video, Voice carry over, Speech-to-speech?
- Accessible web site that include following WCAG Level 2.0 AA for development, maintaining and updating

Thank you for considering protecting the interests of people with disabilities and others with access and functional needs. And thank you for giving these issues your serious attention so that California's requirements for true access for these diverse and growing populations, do not remain empty promises, but becomes reality, and thank you for helping these health plans get better, and not just get bigger!

Sincerely,

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Copy: Shelley Rouillard, Director, Department of Managed Health Care

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