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03.28.16

David Jones, Insurance Commissioner,
c/o Kayte Fisher, Attorney III
California Department of Insurance
300 Capitol Mall, Suite 1600
Sacramento, CA 95814
Via email 03.28.16: Kayte.Fisher@insurance.ca.gov

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

Dear Commissioner Jones:

This letter represents my personal views and is a revised and augmented version of my 1.14.16 letter. 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 I have 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 DMHC to take advantage of this unique funding opportunity for Californian to finally move forward in ensuring real and strong Americans with Disabilities Act compliance, a higher quality of care delivery through improved

accessibility and accommodations information and processes, and choice of providers 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 of offices and facilities is a critical bridge to health care equity for a large and diverse slice of the population.

Contents of this letter:

Recommendations:

Create a statewide single entity that can oversee and distribute funds to address network adequacy that can:

- Improve accessibility to medical equipment and communication,
- Develop statewide database that captures all the Physical-Accessibility Review Survey (PARS) data and is integrated into SB 137 efforts to establish single online provider directory portal,
- Develop tools to evaluate the physical, communication and program access elements of hospitals and health care providers,
- Develop strategies to identify and integrate key disability physical, communication and program access elements into network capacity standards.

Background and Problem

- Population size - People with Disabilities and Others with Access and Functional Needs
- Significant and Widespread Lack of Accessible Providers
- Substandard and unequal treatment
- Network Capacity
- Database information Lacks Programmatic and Communication Access
- Promising Practices
- Fulfilling the Promise

Recommendations:

All merger approved health plans contribute funds that would be equal to or no less than 75 million to create a statewide single entity that can oversee and distribute funds to address the documented critical gaps in network adequacy which specifically affect large groups of **people with disabilities and others with access and functional needs.** Such a fund would lessen the financial impact on individual plans and could accomplish the following, including but not limited to:

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 of accessible examination equipment, communication devices and Video Remote Interpretation equipment as well as mandating "effective use and disability competency" training for the recipients of this equipment. 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 all the Physical-Accessibility Review Survey **(PARS)** data for the purpose of creating a single portal that can be accessed by all plans, as well as members, member services, care coordinators and case managers. The database must be integrated into SB 137 efforts to establish a uniform solution to the inaccurate provider directories problem, through a single, centralized, online reporting provider directory portal.

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

4. The development of specific tools to evaluate the **communication and program access elements** of health care providers.

5. Development of strategies to identify and integrate key disability **physical, communication and program access** elements into network capacity standards 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 advocacy 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 disability access compliance requirements, the history and the requirements of the Rehabilitation Act of 1973 and Americans with Disabilities Act.

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. Identification of current gaps in Medi-Cal managed care and DMHC time and distance access, communication and program access standards.

D. Recommend options for and fund incentives to support network providers, the health plans, and community providers to improve network capacity.

E. Develop audit strategies to address the communication and programmatic access gaps in the currents PARS. This includes clear guidance and a recommended enforcement and monitoring mechanism to address the inconsistent adherence to requirements regarding the flow of PARS information to the Plans' members, member services, provider directories and web sites, care coordinators and case managers. (Evidence of this problem is readily apparent when one examines the health plan's web sites and provider directories. The accessibility information ranges from: health plans who give very clear and specific information via well explained legends of their accessibility codes, to some health plans who merely place a wheelchair logo next to a provider name with no explanation of its meaning, to health plans who provide no access information.)

F. Develop standards for corrective action plans (CAP) 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, and adding directional signage. Larger providers and clinical groups can afford to make changes over time and should create a plan and be held accountable to do so.) Currently the DHCS PARS audits remains incomplete as there is no obligations, unlike all other findings in the FSR audit, for providers to submit and be held accountable for a corrective action plan.

G. Develop standards for member satisfaction surveys to periodically capture and include member feedback regarding specific disability-related issues and accessibility. A tested and validated method to do this is to incorporate the CAHPS Disability Supplement: Item set for people with mobility disabilities https://cahps.ahrq.gov/surveys-guidance/item-sets/mobility/index.html , for people with chronic conditions. https://cahps.ahrq.gov/surveys-guidance/item-sets/index.html, and health

literacy https://cahps.ahrq.gov/surveys-guidance/item-sets/literacy/index.html. In addition, alternate methods for assessing satisfaction of patients who are unable to complete mail surveys (including some people who are blind, or who do not read or do not read well). Use ASL interpreter services for assistance in interviewing deaf members who need assistance in reading.

BACKGROUND AND PROBLEM:

Population size - People with Disabilities and Others with Access and Functional Needs:

The numbers of people who need access related to communication, building, medical equipment, programs 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, remembering, understanding or speaking abilities as well as those who use mobility devices such as wheelchairs, scooters, walkers, canes, crutches and those who do not use devices but have limited ability to walk and use steps.

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 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 and are far greater in numbers than those coded as seniors and people with disabilities (SPD) and aged, blind and disabled (ABD).

Significant and Widespread Lack of Accessible Providers

Current California law governing managed care plans 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 they account for lengthy commute times of rural areas.

The MCO's data presented in Los Angeles on 01.7.16 FSR training, from the **PARS** [[(Attachment C, Physical-Accessibility Reviews (PARs) which is approximately 1 hour part of the 6-7 hour the Facility Site Reviews (FSR) conducted by plans)]] surveys continues to show a significant and widespread lack of accessible providers. 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 scales were present in 3.6% and a height adjustable examination tables were available in 8.4% of the sites
- Other high prevalence access barriers were in bathrooms & examination rooms.

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 causing wider disparities and deteriorating health. This 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 cause 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 or for those who are 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 device is not available).

Network Capacity

Achieving network adequacy remains a challenge for many managed care organizations (MCOs). CMS has proposed that states align their Medicaid network adequacy standards with those used for Qualified Health Plans (QHP) and Medicaid Advantage (MA) plans. However, CMS will not issue standards for Medicaid managed care; states will be required to set their own network adequacy standards. States must assess the geographic location of health care providers and Medicaid enrollees, and then develop standards that take into account distance, travel time, and transportation for the enrollees. The proposed regulations require state Medicaid authorities to develop network adequacy standards for primary care, adult, and pediatric; OB/GYN; behavioral health; adult and pediatric specialists; hospitals; pharmacies; and pediatric dental.

In addition, the specific time and distance standards must include all geographic areas covered by the MCO contract (standards can vary by provider type listed above), and the overall network standards must anticipate:

1. Medicaid enrollment
2. Health needs of specific populations within the MCO contracts
3. Service utilization of Medicaid populations
4. A list of qualified providers (numbers and types), including who is and is not accepting new Medicaid patients
5. Medicaid enrollee English language proficiency and the ability to communicate with enrollees in their preferred language
6. **Access and accommodations for Medicaid enrollees with physical or mental disabilities**

Database information Lacks Programmatic and Communication Access

Physical-Accessibility Reviews (PARs) only address the needs of people with physical disabilities, thus leaving 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 significant 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

Promising Practices

An infusion of funds via grant 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.

Fulfilling the Promise

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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