



GREATER BOSTON
LEGAL SERVICES
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February 1, 2013

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

Re: Comments from Disability Advocates Advancing Our Healthcare Rights (DAAHR)
on Massachusetts Duals Demonstration Three-Way Contracts and Accessibility

Dear Director Bella,

We thank you for carefully considering DAAHR's previous comments concerning the Massachusetts duals demonstration project and accessibility. Your commitment to program-wide accessibility is evident from both the Memorandum of Understanding and Request for Response. Tim Engelhardt recently indicated in an email correspondence with Greater Boston Legal Services that your office would now welcome suggestions on how to address accessibility in the three-way contracts. This letter provides a set of recommended contract provisions related to accessibility that can greatly improve how people with disabilities receive care through the Massachusetts duals demonstration project.

It is well-documented that because of architectural and communication barriers, inaccessible equipment, and provider bias, among other things, individuals with disabilities are far less likely to access quality health care services than individuals without disabilities.¹ Put another way, the health care system all too often fails people with disabilities by not providing

¹ See, e.g., NAT'L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES (2009), <http://www.ncd.gov/publications/2009/Sept302009#Health%20and%20Health%20Disparities%20Research>; Judy Panko Reis, et al., IT TAKES MORE THAN RAMPS TO SOLVE THE CRISIS OF HEALTHCARE FOR PEOPLE WITH DISABILITIES, http://www.tvworldwide.com/events/hhs/041206/PPT/RIC_whitepaperfinal82704.pdf. The physical and programmatic inaccessibility of smaller practices and clinics owned by a physician or physicians is particularly well-documented. For example, one recent large-scale analysis of over 2,300 primary care facilities in California serving Medicaid-eligible managed care patients found that only 8.4% of provider sites had a height-adjustable exam table and only 3.6% had an accessible weight scale. See N.R. Murdick, et al., *Physical Accessibility in Primary Health Care Settings: Results from California On-Site Reviews*, 5 DISABILITY & HEALTH J. (2012).

culturally competent services relating to accessibility.² The enrollees in the Massachusetts duals demonstration project will not derive effective healthcare services or a full and equal benefit from MassHealth and Medicare unless the program ensures that Integrated Care Organizations (ICOs) have the capacity to provide services appropriate to the complex needs of its diverse enrollees. In the context of accessibility, cultural competence necessarily includes a network of providers whose facilities are physically accessible (with, for example, height-adjustable exam tables and universally-designed facilities) and whose programs are also accessible (for example, by offering reasonable accommodations and policy modifications, ASL interpretation, notices and health care information in alternate formats).

This demonstration is an invaluable opportunity to increase the physical and programmatic accessibility and the overall cultural competence of health care delivery to individuals with various disabilities. Moreover, costs to the health care system will be reduced when patients can access care equally, as diseases and illnesses will be prevented or diagnosed earlier, and treated for less money, and patients will not be forced to rely inappropriately on emergency department treatment.³

However, assurance that the influx of dual eligible beneficiaries will receive accessible health care requires much more than just a proclamation that ICOs and providers must comply with the Americans with Disabilities Act (ADA). In fact, a recent review of Medicaid managed care plans in New York showed a *pervasive* lack of ADA compliance even where the managed care contracts contained specific guidelines for ADA accessibility.⁴ The ADA should be a floor upon which broader cultural competency is built. As a result, it is imperative that CMS fully address accessibility as a central component of cultural competence in the three-way contracts between it, the Commonwealth of Massachusetts, and the ICOs and impose obligations on both ICOs *and* the Commonwealth. Moreover, the disability community must be involved in efforts to achieve full accessibility and health equity.

The following chart provides two sets of recommended contract provisions related to accessibility that can greatly improve how people with disabilities receive care through the Massachusetts duals demonstration project.

The first set consists of interrelated provisions to be imposed on *the Commonwealth and ICOs* in the areas of annual enhanced facility (provider) reviews for accessibility, ADA yearly compliance plans, ongoing training, comprehensive assessment procedures, quality measurement/performance improvement, and notice of accommodation rights. As a threshold

² Cultural competence is the demonstrable capacity to provide services in a manner that is physically, linguistically, and attitudinally appropriate to meet the complex needs of a diverse population and addresses the social determinants of health that affect the health access and health outcomes of this population.

³ A recent study by National Institutes of Health researchers found that working-age adults with disabilities account for a disproportionately high amount of annual emergency department visitors. E. Rasch, et al. (2012), *Use of Emergency Departments among Working Age Adults with Disabilities: A Problem of Access and Service Need*, <http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12025/references#>.

⁴ See Center for Independence of the Disabled, NY, *Re: ADA Compliance by Managed Long-term Care Plans in New York State*, <http://dredf.org/healthcare/2012-docs/Analysis-of-ADA-Compliance-by-Managed-Long-Term-Care-Plans-in-New-York-State.pdf>.

matter, we think it is imperative that the Commonwealth be tasked with developing uniform tools to facilitate ICOs in meeting their obligations concerning network accessibility, assessment of the accommodation needs of enrollees, and in training ICOs and providers on disability literacy and the competencies, rights, and the needs of people with disabilities and chronic conditions. In doing so, it is critically important that the Commonwealth be required to consult community-based organizations and individuals with various types of disabilities for their input, as well as make transparency a central element of the project. In addition, the Commonwealth must be tasked with ensuring regular accountability through quality measurement and contract performance standards. Finally, like ICOs, the Commonwealth and its agents must proactively notify all those eligible for this demonstration of physical and programmatic reasonable accommodation rights.

On the other hand, the second category of recommendations consists of provisions to be imposed on ICOs only in the following areas: written materials and education, enrollment and member services, enrollee protections/notices, consumer advisory, and grievance and appeals. These provisions are meant to ensure that ICOs have robust accessibility and accommodation policies, practices, and procedures in key areas of their services.

Your consideration of these recommendations is most appreciated. Feel free to contact us if you have any questions.

Thank you.

Sincerely,

Alexa Rosenbloom, Attorney/Skadden Fellow, Greater Boston Legal Services/DAAHR
Nancy Lorenz, Senior Attorney, Greater Boston Legal Services/DAAHR
Dan Manning, Director of Litigation, Greater Boston Legal Services/DAAHR
Bill Henning, Executive Director, Boston Center for Independent Living/DAAHR
Dennis Heaphy, Health Care Analyst & Organizer, Disability Policy Consortium/DAAHR

cc: Tim Engelhardt, Director, Models and Demonstration Group
Edo Banach, Senior Technical Director

Recommend Interrelated Commonwealth/ICO Obligations

Category	Recommended Obligation(s) for ICOs	(Related) Recommended Obligation(s) for the Commonwealth
<p>Annual Enhanced Facility Site (Provider) Reviews for Accessibility</p>	<ul style="list-style-type: none"> • As part of its network adequacy showing, an ICO must demonstrate that it has providers whose physical locations, diagnostic equipment, and policies and procedures accommodate individuals with disabilities. Providers must also provide linguistically and culturally competent services. To ensure that providers are providing physical and programmatic accessibility, ICOs must conduct an annual enhanced facility site review to assess the physical and programmatic accessibility of provider facilities. • ICOs must train their employees to consistently and periodically administer facility site reviews to their provider networks to determine physical and programmatic accessibility of providers, or contract with trained third-party surveyors to obtain this information, so as to avoid inaccuracies of self-reporting. The programmatic elements of the survey will require interviews of relevant office staff to gauge the capacity of provider offices to offer reasonable modifications of policies, practices, and procedures. • The ICO must make information on the physical and programmatic accessibility of its medical provider and facility networks that it has gotten 	<ul style="list-style-type: none"> • The Commonwealth must produce physical and programmatic accessibility compliance guidelines for providers. The Commonwealth must involve community-based organizations and individuals with disabilities in the development of the guidelines.

	<p>from the facility site reviews available to members (through physical provider directories, websites, and customer service representatives) to enable them to make fully informed provider choices.</p>	
<p>Yearly ADA Compliance Plan</p>	<ul style="list-style-type: none"> • The ICO must submit a yearly ADA compliance work plan to the Commonwealth that describes in detail how it will make its services, programs, and activities readily accessible and usable by individuals with disabilities. The plan must be made public and posted on the ICO’s website. It must also: <ol style="list-style-type: none"> 1) Set goals, list priority activities, and commit resources for increasing accessibility to the services and activities of all ICO providers; 2) Develop percentage goals and a timeline for increasing the physical and programmatic accessibility network, through provider recruitment, education, and technical assistance (e.g. information about tax credits/deductions for purchasing accessible equipment); 3) Include goals related to aspects of accessible health care such as disability literacy and competency training; ongoing identification of existing physical, equipment, communication, transportation and policies and procedures barriers encountered by ICO members; strategies for removing identified barriers; and gathering and incorporating feedback from 	<ul style="list-style-type: none"> • The Commonwealth must have adequate personnel to review ADA compliance plans and must transparently monitor plan compliance (including real-time data reporting). • The Commonwealth must also issue statements of deficiency and review and set plans of correction with clear timelines for compliance (i.e. establish procedures for working on a remediation plan in the event of non-compliance).

	<p>consumers;</p> <ol style="list-style-type: none"> 4) Develop, track, and report on a list of key indicators used by the ICO to track progress toward plan goals; 5) Designate an individual in its organization who is responsible for ADA compliance; 6) Contain an organizational chart showing the key staff people/positions who have overall responsibility and/or practical responsibility for implementing the accessibility and accommodation goals set out in the plan. Include a narrative explaining the organizational chart and describe the oversight and direction; 7) Provide information on the disability literacy and competency training provided to staff and providers (e.g. training schedule, content); and 8) Provide a summary report of data regarding complaints and grievances related to accessibility. 	
<p>Ongoing Training</p>	<ul style="list-style-type: none"> • ICO staff and network providers be must trained in the area of disability literacy and competencies, rights, and the needs of people with disabilities and chronic conditions. Training should be customized as appropriate for different audiences and should be tailored to address specific staff responsibilities (e.g. member services, care coordinators, facility 	<ul style="list-style-type: none"> • Massachusetts must develop standardized training materials for use by ICOs, as well as a statewide education strategy for providers, which all ICOs can use. The Commonwealth must consult with community-based organizations and individuals with disabilities in the development of the training materials and make them public.

	<p>site reviewers). The ICO must consult with community-based organizations and individuals with disabilities in the development of the training materials and make them public.</p> <ul style="list-style-type: none"> • ICOs must conduct ongoing training throughout the demonstration project in the following areas: <ol style="list-style-type: none"> 1) Various types of chronic conditions and disabilities prevalent among duals in Massachusetts; 2) Awareness of personal prejudices; 3) Legal obligations to comply with the ADA and other federal and state civil rights laws; 4) Definitions and concepts such as communication access, medical equipment access, physical access, and access to programs; 5) The types of barriers that adults with various types of disabilities face in the health arena and the resulting access and accommodation needs. 6) Person-centered planning and self-determination, the social model of disability, the independent living philosophy, and the recovery model; 7) Working with enrollees with mental health diagnoses, including crisis prevention and 	<p>Training must be developed in the following areas:</p> <ol style="list-style-type: none"> 1) Various types of chronic conditions and disabilities prevalent among duals in Massachusetts; 2) Awareness of personal prejudices; 3) Legal obligations to comply with the ADA and other federal and state civil rights laws; 4) Definitions and concepts such as communication access, medical equipment access, physical access, and access to programs; 5) The types of barriers that adults with various types of disabilities face in the health arena and the resulting access and accommodation needs. 6) Person-centered planning and self-determination, the social model of disability, the independent living philosophy, and the recovery model; 7) Working with enrollees with mental health diagnoses, including crisis prevention and treatment. 8) Peer-run community-based rehabilitation and
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	<p>treatment;</p> <p>8) Peer-run community-based rehabilitation and long-term support services.</p>	<p>long-term support services.</p> <ul style="list-style-type: none"> Massachusetts must establish ongoing training of the Board of Hearings on disability civil rights and <i>Olmstead</i> requirements.
<p>Comprehensive Health Assessment Procedures</p>	<ul style="list-style-type: none"> Within 90 days of enrollment, the ICO must administer an initial assessment. The initial health screen should identify any access or accommodation needs, language barriers, or other factors that might indicate that the new member requires additional assistance from the ICO. The ICO's comprehensive health assessment must include following domains: <ul style="list-style-type: none"> 1) Accessibility requirements, including but not limited to specific communication needs, need for transfer equipment, need for personal assistance, need for appointments at a particular time of day, need for longer appointments; 2) Equipment needs, including adaptive technology. Accessibility and equipment needs must be regularly reevaluated during all reassessments. Even if a younger person with a disability is capable of transferring independently for a number of years, that ability can diminish fairly rapidly during periods of illness, development of a secondary condition, or even simply due to aging. 	<ul style="list-style-type: none"> Massachusetts should develop a standardized initial health screen to determine disabilities, chronic conditions, and special needs. The Commonwealth must involve community-based organizations and individuals with disabilities in the development of the initial health screen. The Commonwealth should also develop a standardized comprehensive health assessment tool to be used by ICOs that includes domains on accessibility requirements and equipment needs. The Commonwealth must involve community-based organizations and individuals with disabilities in the development of the comprehensive health assessment.

<p>Quality Measurement/ Performance Improvement Concerning Accessibility</p>	<ul style="list-style-type: none"> • ICOs should be required to collect data on the following plan activities or features: <ol style="list-style-type: none"> 1) Identification of members with disabilities in need of reasonable accommodations in accessing services or communicating with the plan; 2) Documentation of notices to members of their right to reasonable accommodations; 3) Documentation of plan guidance to members detailing how to request accommodations; 4) Numbers of staff completing training on policies and procedures for ADA compliance; 5) Up to date description of accessible in-network providers in each county served. 	<ul style="list-style-type: none"> • The Commonwealth must measure and publicly report on patient experience of care related to accessibility (physical and programmatic). The Commonwealth must involve community-based organizations and individuals with disabilities in the development of quality measures relating to accessibility. • The Commonwealth must be required to track and compile categorized data with regard to grievances and appeals concerning the demonstration that have an accessibility element. This information must also be made readily available to the public and to the federal HHS Office of Civil Rights. • The Commonwealth must initiate customer service calls and written checks throughout the demonstration project to assess consumer satisfaction regarding facility and programmatic accessibility. • Plan payment rates should compensate plans for successfully achieving full ADA compliance, including architectural changes, purchase of accessible equipment, and training of ICO and provider personnel.
<p>Notice of Accommodation Rights</p>	<ul style="list-style-type: none"> • The ICO must proactively notify its members and applicants of physical and programmatic reasonable accommodation rights and details on how to request accommodations, accompanied by a variety 	<ul style="list-style-type: none"> • State and county agencies, including enrollment agents and any independent ombudsman office, must proactively notify all those eligible for this demonstration of physical and programmatic

	of explicitly non-exclusive examples of accommodations (such a transfer assistance, ASL interpretation, notices and health care information in alternative formats).	reasonable accommodation rights and details on how to request accommodations, accompanied by a variety of explicitly non-exclusive examples of accommodations (such a transfer assistance, ASL interpretation, notices and health care information in alternative formats).
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Recommended Obligations for ICOs Only

Category	Recommended Obligation for ICOs
Written Materials and Education	<ul style="list-style-type: none"> • Written materials must be available upon request in alternative formats in a timely fashion. • The ICO must also have procedures in place for converting materials to alternative formats when requested. • The ICO shall have a mechanism for a member to make a standing request for all materials to be provided in a specific alternative format.
Enrollment & Member Services	<ul style="list-style-type: none"> • The ICO must train member services staff on cultural and disability competencies and on effective communication to and from individuals with disabilities. • The enrollment systems must generate and maintain records of special needs. • Member services sites and functions must be made fully accessible, including to screen reader software. • Enrollees must be given information sufficient to ensure that they understand how to access medical care through the plan. This information must be made accessible to, and usable by people with disabilities.

<p>Enrollee Protections/Notices</p>	<ul style="list-style-type: none"> • The ICO must provide enrollees with the right to request and receive a copy of his or her medical records, including in an accessible format, and to request that they be amended or corrected. • The ICO must provide enrollees with the right to receive all enrollment notices, informational materials, and instructional materials in a manner and format that may be easily understood. • The ICO must have policies and procedures to inform enrollees of their right to reasonable accommodations.
<p>Consumer Advisory</p>	<ul style="list-style-type: none"> • The ICO must maintain at least one consumer advisory committee and a process for that committee to provide input to the governing board. • The ICO must also demonstrate participation of consumers with disabilities, including enrollees, within the governance structure of the ICO.
<p>Grievances and Appeals</p>	<ul style="list-style-type: none"> • All enrollees must be informed about their ICO’s grievance and appeals processes and the procedure for filing grievances and appeals. The ICO must make all information regarding the grievances and appeals process available to and usable by people with disabilities, and assure that people with disabilities have access to sites where enrollees typically file grievances and requests for appeal.