Dual Eligible Demonstration Projects
Accessibility Related Network Readiness Review Criteria – High Level with Detail

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The underlying premise behind the readiness requirements below is that people with various functional impairments do not and cannot receive equally effective health care services unless facilities are structurally accessible, and plans and providers provide reasonable accommodations and policy modifications[1] (e.g., height-adjustable exam equipment, ASL interpretation for appointments, notices and health care information in alternate formats, extended appointment times) in accordance with federal law.

We support the need for a readiness review prior to enrollment as critical to ensure that the state and managed care organizations (MCOs) review and adapt their regulatory Medicaid requirements, organizational structures, and policies, practices, and procedures for the projected influx of dual eligible beneficiaries. Specific bullet points and topics below relating to provider network surveys and ADA compliance guidelines relate directly to the need for such review and adaptation. At the same time, we strongly believe that the pace and size of many of the demonstration projects, as well as the fact that most MCOs lack experience both with the complex medical needs of the dual eligible population *and* with the long-term supports and services (LTSS) that are now being placed under their administration, will result in individuals falling through the cracks. A readiness review is only a snap shot of one point in time, and cannot substitute for the development of ongoing procedures such as those relating to oversight, continuing staff development, and the ongoing need for out-of-network policies. For that reason we have included all those topics and more in the "network readiness" provisions below.

Bluntly put, no MCO is going to be completely ready and individuals will suffer the consequences, as we have seen in California with the 1115 waiver transition of Medicaid-only seniors and people with disabilities (PWD), but imbedding certain practices through the readiness review may at least give MCOs the incentive to continue getting "ready" as needed even after the initial review has passed. We have a profound desire to avoid a "check the box" approach to network readiness by which a state and its MCOs will establish numerous procedures such as creating plan accessibility guidelines and requiring the administration of provider office surveys that are symptomatic of readiness, but are not linked to any accountability for substantive follow-through or the kind of system transformation that dual eligible beneficiaries need.

[1] The concept of reasonable modifications of policies, practices, and procedures is also referred to hereafter as "programmatic accessibility" to distinguish it from physical or structural accessibility.

Baseline Requirements

- STATE produces physical and programmatic accessibility compliance guidelines and enforceable standards for MCOs, OR if MCOs are allowed to individually establish their own, the state must establish baseline elements for inclusion
- STATE must transparently monitor plan compliance, including real-time data reporting, procedures for working on a remediation plan in the event of non-compliance, and the establishment of set timelines for plans to come into compliance
- STATE must periodically test that MCOs are actually adhering to their own procedures and policies (e.g., policies relating to providing notices, referral, provider network physical and programmatic survey obligations, and TA and incentives to providers over time to raise accessibility levels in the entire network) – and provide evidence of and results of testing upon public request
- STATE must review its *own* agency policies and procedures to ensure they are not interfering with MCOs' and providers' capacity to comply with accommodation policies and procedures (e.g., a state's centralization of benefit application forms, consumer-directed personal assistance timesheets, or other procedures must not make it difficult or impossible for an MCO or its contractors to provide alternate formats or modify necessary documentation for accessibility).
- STATE must establish ongoing training of their own ALJs and managed care grievance and appeal personnel on disability civil rights and *Olmstead* requirements
- STATE must *fully* integrate standards relating to accessibility and appropriate experience and medical expertise into existing time and geographic availability standards (regulatory or otherwise) that are already applicable to MCO provider networks. Without such integrated standards, an MCO could assert that it has recently contracted with a number of accessible providers, but need not establish that any of those providers has sufficient and appropriate expertise and experience for the numerous medically complex and chronic conditions that characterize the dual eligible population, or show that accessible providers are actually taking new patients and located in sufficient proximity to a population that often has only public transportation options.
- MCOs must provide plans and a timeline for training internal beneficiary complaint and appeal personnel on accessibility obligations (i.e., it must be made clear that reasonable accommodation is a legal requirement and not just a "customer service option") and community integration priorities and principles.
- MCOs must be given every incentive to contract with existing specialty care centers, specialists with appropriate expertise, and sufficient contracts with ancillary providers and vendors to take care of particular areas of need before and as they arise. For example, particular attention must be paid to areas like wheelchair vendors and seating specialists, where the depth of need will not be immediately apparent upon member enrollment, but will only arise over time and

cumulatively as existing wheelchairs age and need repair and replacement, and the general population as well as dual eligibles age and assume greater risk of acquiring new functional impairments. The state cannot simply overlay superficial requirements like "engagement of sufficient vendors" at the single temporal point of the readiness review. It must establish requirements that impel plans to anticipate and meet the needs of the dual eligible population, and incorporate additional requirements within those already existing provider network readiness standards that are needed and will continue to apply.

Topical Standards

For the state and MCOs to establish readiness for dual eligible enrollment, each MCO (and the state where indicated below) must produce policies, practices and procedures with respect to the following subject areas:

1. Proactive notification of physical and programmatic reasonable accommodation rights and details on how to request accommodations, accompanied by a variety of explicitly **non-exclusive** examples of accommodations such as transfer assistance, modified appointment/exam room booking procedures, American Sign Language interpretation, and notices and health care information in alternate formats (e.g., Braille, large font print, computer disk, audio).
   - MCO – to all members and applicants
   - MCO- to all contractors, including providers, vendors, CBOs
   - State and county agencies, including enrollment agent and any independent ombudsman office – to all Medicaid and Medicare beneficiaries and members of the public

2. Consultation with beneficiaries who have functional impairments (or their chosen family members or representatives) to identify reasonable accommodations and modifications that are needed for the receipt of equally effective health care services.
   - State and MCO employee training goals, scripts for interacting with beneficiaries who may need accommodations, training modules and technical assistance for provider offices, and procedures for recording and retaining accommodation and modification information within a beneficiary's medical record/Electronic Health Record, and methods for building in ways for beneficiaries and any authorized representatives/proxies to periodically update such accommodation information

3. Capacity of individual providers to respond appropriately
   - Structural and Equipment Accessibility – MCOs must train plan employees to consistently and periodically administer facility site review surveys to their provider networks to ascertain the physical accessibility of individual primary care, specialist, and ancillary facilities, or possibly contract with trained 3rd

party surveyors to obtain this information, so as to avoid the documented inaccuracies of provider self-reporting[2]
- There must be a plan and timeline for incorporating programmatic accessibility surveys through trained plan or 3rd party employees who are already reviewing the physical sites of the plan's provider network, and can engage in interviews of relevant office staff to gauge the capacity of provider offices to offer reasonable modifications of policies, practices and procedures that are needed by beneficiaries
- There must be a plan and timeline for extending survey administration to the physical structures and policies, practices and procedures of relevant LTSS providers who contract or sub-contract with the plans (e.g., behavioral health specialists, adult day centers, DME vendors)
- Sufficient physical and programmatic accessibility information must be made available to beneficiaries to enable them to make fully informed provider choices, through physical provider directories, online websites, and through front-end customer service representatives (and *all* employees must be informed that accessibility information is readily available when needed)

4. Staff Training and Provider Technical Assistance
   - Disability civil rights and disability cultural competence must be incorporated into mandatory employee and customer training modules
   - Each plan must develop a plan and timeline with percentage goals for increasing the physical and programmatic accessibility within its provider network, through provider recruitment, education, and technical assistance (e.g., information about tax credits/deductions for purchasing height-adjustable exam tables, Department of Justice and HHS OCR equipment and ASL guidelines, etc.)
   - The state must initiate "secret shopper" results and customer service call checks *before* enrollment, and ongoing throughout the demonstration project. (this is especially critical in regard to issues relating to LTSS, for those states where plans will be assuming increased or primary responsibility for overseeing Medicaid LTSS)

5. Data Gathering, Review, Transparency, Accountability
   - data on the MCO's successful performance of #1-4, above, must be gathered, and there must be a clear timeline for analyzing information for trends and problems over time, with the data and analysis results made publicly available
   - the state, Center for Medicare and Medicaid (CMS), PWD, and organizations that specialize in quality management, must develop and incorporate quality measures that are specifically intended to capture the degree to which LTSS services and care coordination are patient-centered, patient-directed to the

[2] A number of plans in California voluntarily engaged in surveying primary care provider offices for some years, as documented N. Mudrick *et al.* "Physical Accessibility in Primary Health Care Settings: Results from California on-site reviews," Disability and Health Journal 5 (2012) 159-167, and California has incorporated the survey for mandatory plan use with both primary and specialist providers.

greatest degree possible, and further the individual goals of beneficiaries as well as the systemic goals of community integration and independence for all beneficiaries
- The state must develop a plan and timeline for obtaining and integrating beneficiary input on how to capture quality measures and how to define acceptable outcomes, *before* enrollment begins since it will be vital to have data and quality measures in place that relate to enrollment and assessment

6. Structural Accountability
   - each plan must appoint a high level employee with overarching responsibility for that plan's accessibility policies, practices and procedures, responsibility for disseminating this information and ensuring continuing education within the plan, and overseeing provider education and incentives relating to increasing physical and programmatic accessibility within the network
   - the state must establish sufficient staff to meet its own ongoing oversight, data gathering, and accountability obligations under the readiness requirements

7. Complaint and Appeal Mechanisms
   - develop notices and materials for the public on the availability of internal plan complaint, state and federal grievance and appeal mechanisms, and judicial rights of action, with clear explanations on how the different mechanisms interact and particular regard for exhaustion requirements and limitations timelines
   - notices and materials for beneficiaries must be vetted and approved by CBOs and the direct and supporting legal service groups whose resources will most likely be taxed by supporting beneficiaries with complaints, grievances, and appeal rights

8. Coordination with State and Federal Offices of Civil Rights
   - the state's own office of civil rights, whether located specifically in its department of health services or more generally located in state government must be required to track and compile categorized data with regard to managed care dual eligible demonstration complaints, grievances and appeals with an accessibility component (e.g., ranging from an MCO's refusal or inability to send beneficiary notices in Braille to a specialist's refusal to provide lift assistance to a beneficiary with mobility impairments, from a provider's failure to provide extra appointment time to a beneficiary with developmental disabilities or modify appointment policies to a state ALJ's refusal to provide ASL services for a hearing or an afternoon hearing time to an individual whose treatment regimen for a mental illness makes participation in morning activities very difficult)
   - this information must also be made readily available to the public and to the federal HHS Office of Civil Rights

9. Clear delineation of responsibilities: individual provider, plan, state agencies, complaint and civil rights agencies
   - MCOs and the state must develop and clearly delineate for all stakeholders (e.g., the public, enrollment brokers, providers, LTSS providers, advocates, CBOs, etc.) the topical authority that the plan and individual agencies and departments will hold over such specific areas as mental and behavioral health, HCBS, traditional medical services, durable medical equipment, grievances and appeals, individuals with developmental disabilities, Indian beneficiaries, young adults transitioning out of children's services, beneficiaries in skilled nursing facilities and those in intermediate care facilities, those with vested home and community-based (federal) waiver services, and those who may transition between Medi-Cal eligibility and private health insurance because of income level variance
   - States and MCOs must satisfactorily work out the interaction between overlapping service categories *before* transitions occur so that no beneficiary will have to cycle through a series of phone calls and sort through potentially contradictory information sources because she or he fits within two or more enrollment "categories" or overlapping areas of departmental responsibility.
   - The civil rights agencies that enforce physical and programmatic accessibility and other civil rights (e.g., language access, gender discrimination) must have authority to assist beneficiaries across all benefit categories and specific treatment areas

10. CLEAR and pre-established procedures to apply for and obtain (i) disenrollment, in both emergency and non-emergency contexts; (ii) out of network referrals, in both emergency and non-emergency contexts; (iii) continuity-of-care when such non-medical factors as broken or non-renewed contracts, licensing issues, or other unforeseen and sudden interruptions in established provider relations arise; (iv) independent medical review when a plan and a beneficiary disagree about "medically necessary" services; (v) independent medical and community peer review when a plan and a beneficiary are unwilling or unable to authorize LTSS such that an individual's functional capacity to remain in his or her community is put at risk; and (vi) aid paid pending (i.e., the continuation of the service, treatment, or status that has been denied) until internal and external grievance, appeal and review processes and application timelines are exhausted, wherever aid paid pending is not automatically granted.
   - Information about these procedures and administrative routes should be readily available directly from MCOs and all state agencies and departments involved with managed care or Medicaid administration, as well as independent enrollment brokers, CBOs responsible for providing independent advice and assistance, and any independent ombudsman office