



Disability Rights Education & Defense Fund



March 11, 2016

Shelley Rouillard
Director, Department of Managed Health Care
980 9th Street, Suite 900
Sacramento, CA 95814

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

Submitted via email: publiccomments@dmhc.ca.gov,
Shelley.Rouillard@dmhc.ca.gov, and Mary.Watanabe@dmhc.ca.gov

Dear Director Rouillard,

The Disability Rights Education and Defense Fund (DREDF) and the California Foundation for Independent Living Centers (CFILC) are pleased to submit the following comments regarding pending mergers of Centene-Health Net, Aetna-Humana, Anthem-Sigma, and Blue Shield-Care 1st Health Plan.

DREDF is a national law and policy center that advances the civil and human rights of people with disabilities through legal advocacy, training, education, and public policy and legislative development. CFILC provides information, training and peer support for consumer directed independent living organizations in California, assisting them to improve their effectiveness in creating positive change in their local communities. At the state and federal level, CFILC works to coordinate efforts for positive public policy changes that benefit people with disabilities.

Research has shown that people with disabilities experience significant health and health care disparities that are related to a history of wide ranging disadvantages, which are unavoidable and not primarily caused by the underlying disability. Complex barriers to care contribute to difficulties or delays in getting needed healthcare and increase the

likelihood of poor health outcomes.¹ Because the scale of proposed health plan consolidation is unprecedented, it carries real risks to consumers with disabilities of even greater decreases in access to and choice of providers, inadequate continuity of care, and fewer mechanisms for systemically improving physical and programmatic accessibility.

The disability community has received no specific information about how the mergers will affect people with disabilities in California or any assurances that the long-standing problems we experience accessing care are recognized or will be addressed. Medi-Cal members who are mandatorily enrolled in managed care often are particularly and adversely affected by inadequate continuity of care, limited and inaccessible network providers, and transition issues that will inevitably arise with plan consolidation. For these reasons, we oppose the proposed mergers.

While the plans will argue that greater synergies will be created as a result of the combination of these large plans, they will only be realized if the Department of Managed Health Care (DMHC) requires shared undertakings that will ensure a robust infrastructure for addressing the multiple, long-standing deficiencies in care delivery for people with disabilities and that will improve access to equitable, accessible health care programs and services.

While we oppose the mergers, this letter sets forth specific actions we urge DMHC to take if the healthcare mergers and acquisitions process moves forward. Specifically we recommend the creation of a grant making foundation that would support a wide range of activities aimed at improving access to care for people with disabilities. We also recommend a series of administrative actions that will lead to more equitable care, improved quality of care, and better health outcomes. If implemented, these steps will create the mechanisms required to ensure progress toward reducing barriers to care that people with disabilities typically experience and establish and implement quality improvement goals and methods.

Problem Statement

Health and Health Care Disparities

Extensive research and public health data show that individuals with disabilities experience significant health and health care disparities as compared with the general population. They have higher rates of heart disease and cancer and they die much earlier from those diseases than the general population. Women with disabilities are more likely not to have had a mammogram or to have been screened for cervical cancer.² They also have higher death rates from breast cancer and lung cancer than women without disabilities.³ People with serious mental health conditions die 25 years earlier than people in the general population. Causes include limited access to quality care and health promotion, often due to inadequate and inaccessible provider networks, poor provider disability awareness and training, lack of accessible medical facilities and programmatic accommodations such as accessible medical and diagnostic equipment,

lifting assistance, print materials in alternative, accessible formats, or Sign Language interpreters. Moreover, inflexible policies often deter practitioners from providing extended time for examinations even as additional time is required for effective communication and interaction with individuals with speech, behavioral or cognitive limitations.⁴

Managed Care -- Barriers to Care for People with Disabilities

Public health data suggests that 14 percent of the adult population has significant complex activity limitations that effect their ability to participate in society, including maintaining a household, working and pursuing hobbies. This group includes individuals with limited hearing, vision, reading comprehension, memory recall, and communication ability. Also included are people with intellectual and developmental disabilities and those with mobility limitations who use assistive devices such as manual and motorized wheelchairs, scooters, walkers, canes, and crutches. Many others have difficulty walking, climbing and navigating stairs.⁵ In California, individuals in this population comprise a significant percentage of enrollees in publicly funded managed care programs including Medi-Cal, and Cal MediConnect.

People with disabilities enrolled in such health plans only have access to providers participating in the plans' networks and therefore do not have the luxury of switching to an accessible provider who does not participate in the plan. Consequently, managed care plans should take accessibility and capacity of providers to accommodate people with diverse impairments into consideration when they determine provider network adequacy, yet few do so. They also should ensure that members with disabilities have the same choice of providers that is available to members who do not have disabilities by proactively recruiting providers that meet minimum physical and programmatic accessibility requirements and helping and supporting current providers to meet such obligations. These actions are necessary both to avoid discrimination against disabled members and to prevent poor health outcomes. Again, few do so.

Physical and Programmatic Accessibility Absent in Network Adequacy Standards

Managed care health plan provider networks in California must currently meet certain standards related to geographic location of individual providers and associated time, distance, and transportation elements. Yet no such standards have been adopted to ensure that practitioners in that network are located in architecturally accessible facilities and can provide programmatic access by such means as accessible diagnostic equipment and weight scales and capacity to modify policies so exam times can be extended when required to accommodate individual patient needs.

For example, 15 gynecologists might participate in a provider network who are within the allowable distance and time requirements of a member who uses a wheelchair, but few or none of these gynecologists have height adjustable exam tables, patient lifts, or available trained personnel to assist with a transfer, thus none can provide a member who uses a wheelchair with an effective examination. Indeed, research examining

accessibility for over 2300 primary care practices in California serving Medi-Cal beneficiaries revealed that only 8.4 percent had height adjustable exam tables and 3.6 percent had accessible weight scales.⁶ Moreover, managed care plans currently do not have mechanisms in place to assess programmatic accessibility and even fewer policies exist to help and support network practitioners to accommodate patients with disabilities.

Unequal treatment is exemplified when providers skip needed tests, do not weigh patients, and do not communicate effectively because accommodation needs have not been identified and recorded and appropriate arrangements made such as lifting assistance or additional time for an examination. When people with disabilities and others with access and functional accommodation needs have to struggle to find accessible healthcare, some find the effort simply too exhausting, overwhelming, and degrading. This leads to postponing or avoiding care, which results in a downward spiral of delayed diagnosis, worsening conditions, and deteriorating health. Eventually these individuals require more extensive and expensive healthcare and they experience diminished opportunities for healthy and productive lives.

Recommendations

- 1. If a merger is approved, a minimum of \$50 million in funding should be committed to establish an endowment to create a Disability Health Foundation. The foundation will focus on funding programs, services, research, evaluation, and technical assistance to increase and improve access to equitable, effective healthcare for people with disabilities.**

The Disability Health Foundation should employ a transparent process to establish a strong and sustainable infrastructure that will provide a long-lasting public benefit and that will include:

- A planning process that engages the disability community in a substantial way and that draws on the perspectives and expertise of the diversity of the disability community
- Criteria that ensures the governing board will have the appropriate, disability-related expertise and experience, and will reflect and represent the diversity of the disability community
- A board selection process that is deliberate, open, and accessible to people with disabilities and the public, and is free of conflict of interest
- An organizational structure that is open and accountable to the public, coupled with practices that offer many opportunities for community input and ongoing, meaningful community involvement.

2. If the merger is approved, a minimum of \$75 million in funding should be allocated to establish a statewide technical assistance entity that can evaluate managed care provider networks and fill critical gaps in adequacy with respect to the needs of people with disabilities.

The objectives of the entity would be to:

- Establish Accessibility Priorities: Create and implement a plan that sets priorities regarding which primary, specialty, and other provider sites must be made accessible first (but not only) taking into account geographic and transportation accessibility and other critical factors such as provider specialty, expertise, population need, other cultural factors (i.e., language spoken), and gender and age of provider. The entity would fund carefully selected network provider sites including primary care, specialty providers, Federally Qualified Health Centers, clinics, and urgent care locations to upgrade and improve the capacity of the sites to provide programmatic accommodations for people with disabilities. Methods could include, for example, purchase of accessible examination equipment, communication devices, and Video Remote Interpretation equipment. Funds could also be used to create model policies and procedures for provider offices that would define how to locate and provide needed accommodations. They could also be used to train provider medical staff on the use of the equipment and on issues related to disability literacy, competency and awareness.
- Establish a Statewide Physical and Programmatic Access Database: Establish a centralized statewide uniform database that captures the information currently being collected by managed care health plans using the Department of Health Care Services (DHCS.) –mandated Physical Accessibility Review Survey (PARS) data. Incorporate the information that is currently available for primary care physicians, and later for specialty and other providers, into healthcare provider directories in order to ensure health plan members have access to available information about accessibility of network providers. If a statewide digital provider directory is established, as several organizations have recommended, include physical and programmatic accessibility information for each provider listed in the directory.
- Develop Survey Instruments: Develop specific survey instruments that can be used to evaluate both the physical and programmatic access elements of healthcare provider offices, acute care hospitals, long-term care facilities, treatment centers, pharmacies, mental health providers, adult day facilities, behavioral health centers (both inpatient and outpatient) and other locations where healthcare services are delivered. Such instruments should identify the practices' capacity to provide, for example, lifting assistance, Sign Language interpreters, oral interpretation, assistive listening devices, computer assisted

real-time transcription, longer appointments, print materials in alternative formats, text messaging, email, and capacity to use 711 relay services.

- Establish a Task Force: Establish a statewide task force charged with: 1) identifying systemic barriers to care for people with disabilities (i.e., poor continuity of care when members move from one plan to another, lack of meaningful quality improvement measures related to accommodating people with disabilities in healthcare settings), and 2) setting priorities and action steps for needed reforms that take advantage of existing policy levers. The task force should include representatives from key associations of providers, community clinics, medical groups, hospitals, health plans, and representatives from disability advocacy groups as well as DMHC and DHCS. Examples of task force activities include:
 - Exploring policy levers that could lead to increased physical and programmatic accessibility of healthcare providers such as including disability accommodation expenditures in Medical Loss Ratio (MLR) calculations and linking MLR allowances to quality improvement measures
 - Identifying gaps in current methods for measuring network adequacy related to physical and programmatic accessibility in managed care provider networks that also take into account geographic location of network providers along with time, distance, transportation and other factors
 - Identifying specific standards for network adequacy that includes physical and programmatic accessibility and methods to integrate information about key elements reflecting compliance with these standards into a centralized, statewide, uniform database used to report PARS data and also into any future statewide digital provider directory
 - Incentivizing methods for increasing provider education related to disability accessibility compliance requirements as set forth in section 504 of the 1973 Rehabilitation Act and the 1990 Americans with Disabilities Act
 - Incentivizing methods for identifying physical and programmatic access deficiencies among small network providers and encouraging installation of small-scale access elements such as Braille signage or grab bars
 - Incentivizing methods for identifying physical and programmatic access deficiencies among larger network providers and promoting methods to support and measure continuous access improvement among these providers over time
 - Incentivizing methods for measuring member satisfaction that captures feedback on specific disability related barriers, problems and accessibility

issues. (The CAHPS disability supplement is one tested and validated method for capturing member feedback that should be considered.)

Conclusion

The disability community is experiencing significant pent-up frustration from the slow pace of removing barriers and improving access to equitable health care for people with disabilities in California. The proposed mergers present yet another potential structural obstacle to real and meaningful action that would reduce well-known barriers to care for people with disabilities. Thus far, merger plans have shown no recognition or interest in resolving these systemic and discriminatory barriers to care and indeed the barriers may be compounded if the mergers go forward. We therefore strongly urge DMHC to provide much-needed leadership on these pressing issues by adopting our recommendations, if the mergers are implemented.

Thank you for your attention to our concerns.

Sincerely,



Susan R. Henderson
DREDF Executive Director



Teresa Favuzzi
CFILC Executive Director

Endnotes

¹ Gloria L. Krahn, Deborah K. Walker, Rosaly Correa-De-Araujo, "Persons with Disabilities as an Unrecognized Health Disparity Population," *American Journal of Public Health* 105 S2 (2015): S198-S206.

² Sze Y. Liu, Melissa A. Clark, "Breast and Cervical Cancer Screening Practices among Disabled Women Aged 40–75: Does Quality of the Experience Matter?" *Journal of Women's Health* 17(8) (2008):1321–1329.

³ Ellen P. McCarthy, Long H. Ngo, Richard G. Roetzheim, Thomas N. Chirikos, Donglin Li, Reed E. Drews, Lisa I. Iezzoni, "Disparities in Breast Cancer Treatment and Survival for Women with Disabilities," *Annals of Internal Medicine* 145.9 (2006):637–45; Lisa I. Iezzoni, Long H. Ngo, Donglin Li, Richard G. Roetzheim, Reed E. Drews, Ellen P. McCarthy, "Treatment Disparities for Disabled Medicare Beneficiaries with Stage I Nonsmall Cell Lung Cancer," *Arch Phys Med Rehabil*, 89.4(2008):595–601.

⁴ National Council on Disability, "The Current State of Health Care for People with Disabilities," September 30, 2009.

⁵ Complex activity limitation affects their ability to participate in society, including maintaining a household, working, and pursuing hobbies; see Altman, Barbara & A. Bernstein, *Disability and Health in the United States, 2001-2005*" (Hyattsville, MD: National Center for Health Statistics, 2008). Complex activity limitation is captured through four measures: any limitations in social or leisure activities, any difficulty or inability to work, self-care limitation (reflected by any ADL or IADL limitation), and an overall combination measure, which reflects any individual or combination of limitations in the first three measures.

⁶ Nancy R. Mudrick, Mary Lou Breslin, M. Liang, Silvia Yee, "Physical Accessibility in Primary Health Care Settings: Results from California On-Site Reviews," *Disability and Health Journal* 5 (2012):159-167.