

June 29, 2015

Sent via electronic mail to
Medicare-Medicaid Coordination Office, MMCOCapsModel@cms.hhs.gov
Tracy Meeker, DHCS, Tracy.Meeker@dhcs.ca.gov

Re: Comments on Updated CA Reporting Requirements

Dear Sirs or Madams:

Disability Rights Education and Defense Fund (DREDF) appreciates the opportunity to submit comments on the updated California State-Specific Reporting Requirements for Contract Year 2015, released by the Centers for Medicare and Medicaid Services (CMS) June 22, 2015. Our comments below are directed primarily at the newly added physical accessibility requirements in Measure CA3.1. With regard to other newly added requirements, we support the comments submitted by our colleagues at Justice in Aging with regard to plan reporting of HRA and ICP completion, as well as their comments on the need for additional measures on rebalancing and person-centered care. Please note that while our own comments provide greater elaboration on Measure CA3.1, our two organizations are in fundamental alignment on the subject.

Physical Accessibility

To begin with, we want to applaud CMS for incorporating additional needed specificity in its reporting requirements for physical access compliance. We note that the California three-way contract has always indicated that MMPs must provide services to enrollees that (at paragraph 2.11.1.2):

Reasonably accommodate Enrollees and ensure that the programs and services are as accessible (including physical and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities, and shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services from the Contractor by:

[an extensive list of examples that reference the provision of flexible appointment times, effective communication, and “individualized assistance.”]

DREDF strongly supports CMS’s decision now to back up these requirements by establishing concrete reporting obligations that will hold contractors to their responsibility to ensure physical accessibility. In particular, the updated requirement to report on the specific position or officer within the plan that is responsible for physical

access compliance, as well as the requirement for plans to report on their process for documenting physical access non-compliance, the actions taken to remediate non-compliance, individuals responsible for remediation, the timeline for remediation, and monitoring and oversight of the remediation process. We further commend that CMS and the state will be under an obligation to evaluate and verify plan data, including the plan's annual assessment of its Annual Physical Access Compliance Policy which will require identification of completed plan objectives and recommended interventions.

We recommend that the reporting requirement include an additional element that explicitly addresses the need for plans to demonstrate progress from year to year in achieving physical accessibility among network providers, including specialists and ancillary service providers. We state this concern in part because as currently written, Measure CA3.1 requires the Physical Access Compliance Policy to “clearly describe the policies and procedures for maintaining compliance with the Americans with Disabilities Act (ADA) physical access requirements.” DREDF has participated in research conducted by 3rd party physical accessibility surveyors in over 2800 managed care primary care provider facilities.¹ The research established that an accessible weight scale was present in 3.6% and a height adjustable examination table in 8.4% of the sites. Other high prevalence access barriers were in bathrooms and examination rooms. “Maintaining” this state of ADA compliance, or non-compliance, is clearly not in the best interests of MMP members with disabilities. There is little reason to suspect that these compliance figures are any better for Medicare providers given that some inaccessible providers would be common to both Medi-Cal and Medicare plan networks, and the fact that CMS does not appear to have in place a system for monitoring and enforcing physical accessibility among Medicare providers. Measure CA3.1 should require the Physical Access Compliance Policy to “clearly describe the policies and procedures for improving provider network compliance with the ADA.”

Programmatic Accessibility

Our primary concern with the updated reporting requirement is their complete exclusion of any programmatic accessibility element. We do not understand why MMPs should have absolutely no requirement for reporting data on programmatic accessibility when they have been subject to an existing obligation to remove programmatic barriers and provide reasonable accommodations and modifications under the three-way contract, as quoted above. Moreover, the plan's obligations under Section 504 of the Rehabilitation Act as both a recipient of federal funds and a public accommodation under Title III of the ADA, as well as the state's obligations under Title II of the ADA, all clearly include an obligation to provide reasonable accommodations and modifications to people with disabilities, whether members, family or companions of members, plan applicants, or members of the public. California's own state laws, some of which predate the ADA, also hold plans responsible for not only physical accessibility but programmatic accessibility.

¹ Nancy R. Mudrick, Mary Lou Breslin, Mengke Liang, and Silvia Yee, *Physical Accessibility in Primary Health Care Settings: Results From California On—Site Reviews*, Disability and Health Journal 5 (2012) 159-167.

We strongly recommend that the draft update include the gamut of ADA accessibility requirements among the accessibility reporting required of MMPs. If CMS is unprepared to imminently add reporting requirements relating to non-physical accessibility, then the updated requirements should be absolutely clear that the legal requirements of federal accessibility and California-specific law continue to fully apply and are distinct from the updated CA specific reporting requirements. In particular, the reporting requirements should reiterate the requirements of paragraph 2.11.1.2 and its list of accommodations, and include an annual reporting requirement on the plan's development of a facility site review tool that will enable it to capture, validate, and report data concerning the provision of programmatic accommodations within its provider network. This tool should capture the degree to which plan providers meet the requirements of Title III of the ADA, 28 CFR, § 36.302:

(a) General. A public accommodation shall make reasonable modifications in policies, practices, or procedures, when the modifications are necessary to afford goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the public accommodation can demonstrate that making the modifications would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations.

In addition, we strongly recommend that the Physical Access Compliance Officer become the "Accessibility Compliance Officer." We understand that California's current Attachment C of the FSR only captures physical accessibility, and specifically the elements listed in the provider site assessment tool section of the updated reporting requirements. Attachment C was applied to MMPs in Dual Plan Letter 13-003, issued July 17, 2013 by California's Department of Health Care Services and MMPs, by now, have had the opportunity to administer the MMP to their new networks, including non-"high volume" specialists. However, CMS' reporting requirements must at least be as motivated by the health care needs of dual-eligible members and the primary goal of integrated care to provide "the right care at the right time in the right place," as the practical consideration that the state's MMPs are now able to report with some ease on data that they have time to gather, process and analyze. To be clear, the draft reporting requirements are a very significant improvement on plans simply gathering accessibility information without public transparency, data validation, or any practical consequence or obligation to improve provider network accessibility. But dually-eligible beneficiaries need the full range of their civil rights, and deserve to have MMPs report on their compliance with physical *as well as programmatic* accessibility.

As a final point, we would like to ask CMS to consider how these physical accessibility reporting requirements, as well as programmatic accessibility reporting requirements, could be incorporated over time within the reporting obligations of other state dual integration projects. The FSR requirement in California, and the development of physical and programmatic accessibility tools, is wholly possible in other states with sufficient policy encouragement and incentivization. We would welcome the opportunity to work with the Medicare-Medicaid Coordination Office and CMS on increasing ADA compliance and accessibility among the providers who serve dually-eligible individuals and other people the disabilities and chronic conditions.

Thank you again for the opportunity to comment.

Sincerely,

A handwritten signature in black ink, appearing to read "Silvia Yee". The signature is written in a cursive style with a horizontal line underlining the name.

Silvia Yee
Senior Staff Attorney