

Promoting Physical and Programmatic Accessibility in Managed Long-Term Services and Supports Programs

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We reviewed managed long-term services and supports (LTSS) contracts for nine states in order to understand the extent to which they promote physical and programmatic accessibility for enrollees with disabilities. Medicare/Medicaid duals demonstration contracts for Virginia, Illinois, Massachusetts, Michigan, New York, and South Carolina contain provisions that represent a ground shift in federal expectations and requirements for physical and programmatic accessibility of managed care organizations (MCOs) and the providers with whom they contract. These contracts contain certain uniform provisions that reflect the influence of the federal readiness review process required of states and MCOs that took advantage of Medicare/Medicaid financial alignment demonstration options made available through the Affordable Care Act.¹ Although these contracts represent progress, especially because they include provisions related to the social model of disability, some process weaknesses make it difficult for the full benefit of the new provisions to be realized. Nevertheless, the duals demonstration contracts represent a promising practice and an important step forward.

Outside of the duals demonstrations, a review of Medicaid managed LTSS contracts for Minnesota, New Mexico, and New Jersey revealed significant differences compared with the duals demonstration contracts. The Minnesota and New Mexico contracts are substantially different from the duals demonstration contracts and do not reflect an equivalent understanding of barriers that people

with disabilities experience when they attempt to access clinical care. While they reference compliance with the ADA, they do not include significant provisions related to physical and programmatic accessibility, other than communication for people with hearing disabilities. On the other hand, the New Jersey Medicaid contract is more closely aligned with the duals demonstration contracts. It also stands out among all nine contracts, in that it calls for the state to develop a physical and programmatic accessibility survey instrument that MCOs are required to use to evaluate accessibility of their provider network. It also calls for MCOs to indemnify the State from liability that results from any failure of the plan to be in compliance with the Americans with Disabilities Act (ADA). While it is not clear whether this provision is enforceable, it reflects the State's understanding that such liability exists, whether or not program administrators understand the actual impact of inaccessible facilities and programs on patient health and health outcomes.

Introduction

People with disabilities require that health plans and health care provider facilities and services be physically and programmatically accessible in order for healthcare to be effective and equitable. Practically speaking, however, both MCOs and providers often lack disability awareness and therefore are unfamiliar with what physical and programmatic accommodations people with disabilities require and how to provide them. As awareness of these barriers and their impact on health outcomes for

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people with disabilities has increased, advocates and federal policy makers have identified new pathways that potentially can improve access, such as including physical and programmatic accessibility, disability cultural awareness, and provider education and training requirements in federal Medicaid managed care contracts.

In order to evaluate the content of certain Medicaid contracts and the potential role contract requirements could play, we identified ten key contract elements that are especially important if MCOs and providers are to meaningfully improve their capacity to accommodate people with disabilities. These elements are based on our experience of typical barriers to care and services and also in part on requirements the Centers for Medicare and Medicaid Services (CMS) used to evaluate how prepared states and MCOs were to undertake new Medicare-Medicaid dual eligible demonstration projects following enactment of the Affordable Care Act. The elements include, for example, a requirement that policies and procedures be developed to ensure compliance with the ADA, Section 504 of the Rehabilitation Act, and relevant state law; a requirement that MCOs carry out an on-site accessibility survey of health care provider facilities and medical equipment and of their capacity to accommodate people with disabilities; and a requirement for disability awareness and competency training for both plan and provider staff.

Next, we evaluated various types of federal Medicaid contracts with states to determine whether the key elements were included, along with the extent to which the contracts contained enough detail and guidance so that implementation was practically feasible. We examined Medicare-Medicaid duals demonstration contracts for Virginia, Illinois, Massachusetts, Michigan, New York, and South Carolina. We also reviewed a Medicaid 1115 waiver program in New Mexico, a voluntary managed-care program for dual eligible seniors in Minnesota, and a Medicaid managed long-term services and supports program in New Jersey.

Key Contract Elements

We identified the following ten key contract elements that are especially important if MCOs and providers are to improve their capacity to accommodate beneficiaries with disabilities.

1. Policies and procedures that are required to ensure compliance with the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and relevant state law.
2. Provisions to increase disability awareness and cultural competency among providers, including required disability awareness and competency training of network clinical and other provider staff and assurances that the plan and providers understand the goals of community integration, independent living, and person-centeredness for people with disabilities.
3. Provisions related to assuring that beneficiaries receive reasonable accommodation, policy modifications, and auxiliary aids and services when required to ensure equitable and effective care and services.
4. Requirement that MCOs assign a specific person responsible for overseeing plan and provider actions aimed at achieving physical and programmatic accessibility of facilities and services and other contracted services.
5. Delineation of specific actions required of the health plan itself.
6. A requirement that MCOs carry out an on-site accessibility survey of health care provider facilities that includes availability of accessible medical equipment, such as exam tables and weight scales, in individual practices; and a requirement that such surveys not be delegated to network providers to complete.
7. A requirement that MCOs assess the capacity of clinical and service providers to provide accommodations such as ASL interpreters, print materials in alternative, accessible formats, and extended exam time; and a requirement that such surveys may not be delegated to network providers to complete.

8. A requirement that MCOs use a specific accessibility survey tool for on-site evaluation of physical and programmatic accessibility.
9. A required MCO compliance or other plan that sets forth actions to increase and improve accessibility, such as recruiting additional accessible providers or incentivizing accessibility modifications or equipment purchases when network providers are deemed to be physically inaccessible or do not have accessible medical equipment.
10. A required plan for ensuring that members have ready access to full and accurate information on provider accessibility, including availability of accessible medical equipment.

Among the six duals demonstration contracts that we reviewed, Virginia, Illinois, and Massachusetts include some language related to each of the ten key elements. South Carolina and Michigan each include at least some language related to nine of the ten key elements, but do not include a requirement that a survey instrument be used to evaluate physical accessibility of provider facilities. New York includes some language related to eight of the ten key elements, but does not include a requirement to survey certain provider programmatic accessibility elements and does not require that a uniform survey instrument be used to evaluate physical accessibility of provider facilities.

Among the non-duals-demonstration contracts, only New Jersey covered most of the ten key elements. In contrast, New Mexico's Medicaid managed LTSS contract includes language related to only six key elements, with a very strong emphasis on culturally and linguistically competent services, but with almost no recognition of other access and accommodation needs of beneficiaries with disabilities. Minnesota's contract covers only two elements, and it does so with limited scope. The Minnesota contract requires that plans provide materials to members in accessible formats, that language accommodations be provided, and that linguistic competence includes providers who serve

enrollees who are deaf and use Sign Language or other modes of communication. The contract also requires that any readily available information on physical accessibility of provider facilities be made available. (See Analysis of Contract Responsiveness to Ten Key Contract Elements below for a detailed discussion of each state's contract.)

Promising Practices in Duals Demonstration Contracts

Intersection of social and medical models

The duals demonstration contracts contain important provisions that recognize the interaction of the social model of disability with the medical and treatment model. That is, they recognize that people with disabilities experience physical and programmatic barriers to care that contribute to health disparities and poor health outcomes. Further, the presence of specific contract provisions encourages actions on the part of MCOs and providers that can potentially reduce these barriers and improve access to care.

The duals demonstration contracts also include references to important principles embodied by the social model such as integration, independent living, person-centered planning processes, equal access to services and programs, and disability cultural competency. The contracts each require at least some methods for promoting awareness of these important elements among plan staff and providers, along with actions required to ensure that enrollees have physical access to provider facilities and services and receive appropriate accommodations.

The addition of these proactive requirements represents an important and fundamental shift in how federal policymakers perceive the role and responsibility of states, managed care organizations, and providers in ensuring that barriers to care do not result in discrimination against enrollees with disabilities. However, this shift has taken place largely in the dual eligible demonstration program context and does not appear to be consistently represented in the non-duals-demonstration contracts. Often, those

contracts simply require that plans and providers attest to the fact that they are compliant with federal disability rights laws, including the ADA, even though simple attestation fails to trigger or account for the mechanisms necessary to ensure that practical compliance is taking place at all levels of care delivery.

Enhanced physical and programmatic access language

A number of themes consistently appear in the duals demonstration contracts that embody the new shift. For example, the contracts uniformly recognize that plans and providers have legal obligations under the ADA, other federal disability rights laws, and certain state laws. Importantly, they also uniformly recognize that the ADA is not self-executing, therefore plan staff and providers require training on the fundamental principles of the social model, including disability awareness, cultural competency, independent living, and ADA/Olmsted requirements. Training is also required on methods for complying with the ADA that specifically involves accommodating enrollees with physical, communication, and cognitive disabilities.

Most of the duals demonstration contracts emphasize and specifically mention methods for achieving effective communication, such as ASL interpreters, use of TTY devices and video relay services, and provision of print materials in accessible alternative formats. Most call for policies and procedures to achieve effective ADA implementation, and they call for identification of a person charged with oversight and compliance. In some cases, the contract calls for a generic compliance officer charged with overseeing all aspects of the demonstration, while in other cases contracts call specifically for an ADA compliance officer. Detailed language developed by CMS during the readiness review process most likely accounts for this widespread uniformity.

Missing Elements in Duals Demonstration Contracts

Uniform access survey instrument

While the new direction of the duals demonstration contracts indicates important progress, the contracts vary in the processes needed to ensure that activities intended to improve physical and programmatic accessibility are carried out in a meaningful way. Some contracts contain no such provisions whatsoever. For example, most contracts contain language directing the MCO to conduct either surveys or on-site visits of provider facilities in order to collect sufficient information to determine both physical and programmatic accessibility. Yet only one duals demonstration contract references a specific survey instrument that providers are required to use to evaluate accessibility of their facilities. Contracts also vary regarding what information plans are expected to collect during on-site visits.

For example, Michigan instructs the MCOs to collect sufficient information from providers to assess compliance with the ADA, yet no guidance is provided about what constitutes sufficient information or what survey tool might be appropriate to use. The Virginia contract instructs plans to determine whether the network provider has specific accommodations for people with physical disabilities, such as wide entry doors, wheelchair access, accessible exam rooms and tables, lifts, scales, bathroom stalls, grab bars, or other accessible equipment, but the contract does not specify a survey instrument that would enable plans to consistently collect this information.

The New York contract presents unique problems in that it depends upon the use of ADA attestation forms that are to be completed by providers who have limited knowledge of ADA requirements or principles of accessibility. Moreover, the attestation form does not reference elements of programmatic accessibility other than auxiliary aids and availability of ASL interpreters, which typically are combined into one question. Therefore, the information being attested to can be inaccurate

or incomplete.² Moreover, because untrained personnel complete the attestation forms, facilities might be inaccessible when the forms indicate that they are accessible.

Lack of a uniform survey instrument likely makes it very difficult for plans to provide accurate, updated information, either online or in printed directories, about provider accessibility and capacity to accommodate enrollees with disabilities. Thus, a long-standing barrier to effective care continues to be perpetuated when enrollees are not able to identify providers who can meet their needs.

Programmatic accessibility specifics

Duals demonstration contracts frequently refer to the term programmatic accessibility, yet the contracts we examined do not define it. Advocates and analysts coined this term to encompass the wide variety of ADA accommodations that people with disabilities might require in clinical healthcare settings, including accessible medical diagnostic equipment, language and communication accessibility, provision of auxiliary aids and services, and modification of policies and practices.³ They promoted the term with federal agency officials during the CMS readiness review process and celebrated its appearance in duals demonstration contracts. While in most cases it can be inferred from the contract language that programmatic accessibility encompasses a wide range of accommodations, MCOs and providers do not have an adequate reference point to understand its full meaning. This makes it difficult to facilitate meaningful compliance, and future contracts should explicitly define the term.

Plan and provider training content

While most of the duals demonstration contracts include specific requirements for plan and provider training on a wide range of topics, there is little detail indicating how the training curricula will be designed or who be involved in identifying training content. These decisions are left to individual plans, which likely will result in training inconsistency and lack of uniformity.

Provisions of the Non-Duals- Demonstration Contracts

Managed LTSS contracts for Minnesota, New Mexico, and New Jersey revealed a stronger emphasis on the medical model, and less awareness of barriers to care that people with disabilities encounter and the potential role that plans can play in reducing those barriers, in collaboration with providers and others. While the duals demonstration contracts contained at least some language related to most of the ten key contract elements, Minnesota and New Mexico touched on many fewer elements. New Jersey, on the other hand, was more similar to the duals demonstration contracts, containing language related to most of the key elements.

Minnesota's contract for its mandatory Medicaid managed LTSS program and its voluntary program for dual eligible beneficiaries specifically requires compliance with the ADA, primarily for communications with enrollees. The contract mentions that communication with enrollees should include information about services to which the enrollee is entitled, including factors such as physical accessibility when it is reasonably available to the plan. The contract does not mention other provisions of the ADA that would be applicable to both the plan and providers or methods for collecting information about accessibility of providers. The contract emphasizes making information available in alternative formats for people who have visual impairments or reading proficiency difficulties. It specifically calls for written materials to include a reference to availability of alternative formats and inclusion of methods to access a TTY and relay service number. The Minnesota contract does not reference any other physical or programmatic accommodation methods, social model training requirements for plans or providers, or the requirement for a compliance officer.

New Mexico's statewide 1115 waiver for Medicaid services, including LTSS, references a requirement to comply with the ADA and requires that the geographic location of providers take into account issue such as distance, travel time, and whether the location

provides physical access for members with disabilities. It also requires policies and procedures that are to take these factors into account. The strength of the New Mexico contract, however, is its requirement to develop and implement a cultural competence/sensitivity plan.

The MCO is required to describe efforts to promote the delivery of services in a culturally competent manner to all members, including members who have hearing impairments, limited English proficiency, speech or language disorders, physical disabilities, developmental disabilities, differential abilities, and diverse cultural and ethnic backgrounds. While the contract specifically targets cultural competence training for member services staff and providers, there is no indication that this training is intended to encompass physical and programmatic accessibility factors other than possibly linguistic needs of deaf and/or hard of hearing individuals. It does, however, specifically call for development and implementation of a plan for interpretive services, referencing both Sign Language and spoken language interpreters. It also calls for identification of a full-time compliance officer and that policies and procedures be made available in accessible formats upon request.

The New Mexico contract does not call for physical and programmatic surveys or on-site reviews of provider facilities and services. It emphasizes cultural competency, primarily in the language context, which includes ASL interpretation, but does not contain provisions related to other areas of accessibility and accommodation. The New Mexico contract is similar to the Minnesota contract in its emphasis on effective communication. Similarly, neither contract addresses in a major way factors related to physical and programmatic access for individuals other than those with communication impairments.

The New Jersey contract, in comparison, contains some language related to eight of the ten key elements. Two provisions in particular stand out. The New Jersey contract requires that the MCO assess its provider network and certify that its providers are compliant with the ADA.

Specifically, the contract calls for the use of a standard survey instrument that will be developed by the State. It also requires the plan to warrant that the State will be held harmless and indemnify the State from any liability that results from a failure of the plan to be in compliance with the ADA. While this provision may not be enforceable, it indicates that the state is aware of potential liability when plans and providers do not effectively implement the ADA.

CMS Readiness Reviews

CMS initiated a comprehensive readiness review process for states and MCOs interested in participating in the Medicare-Medicaid duals demonstrations that commenced following the enactment of the Affordable Care Act. Readiness reviews included a specific focus on areas and processes that have a direct impact on the beneficiary's care, including assessment processes, provider network development and maintenance, care coordination, and the participating health plans' staffing and staff training. CMS and the state worked collaboratively to develop state-specific readiness review tools, based on stakeholder feedback collected through public meetings and other means. Content for the readiness review tools was also derived from the memorandum of understanding (MOU) between CMS and the state, applicable Medicare and Medicaid regulations, state specific procurement documents, and experience of CMS working on previous tools.

Readiness review tools used by the six duals demonstrations we reviewed reflected the important influence of the MOUs. For example, the MOU between CMS and Illinois required that the readiness review show that participating MCOs have an adequate network that addresses the full range of beneficiary needs and the capacity to ensure all beneficiary safeguards and protections. The Illinois MOU also contained a specific provision related to compliance with the Americans with Disabilities Act (ADA). It stipulated that CMS and the state recognize that successful, person-centered care requires physical access to buildings, services, and equipment, and flexibility in scheduling and

processes. It required that ASL interpreters be provided for deaf and hard of hearing beneficiaries and recognized the need for both staff and provider training on accessibility and accommodations. It references the independent living model and the role that cultural competency plays in ensuring effective care and services. The MOU also specifically recognized the Olmstead decision and requires that beneficiaries with LTSS needs be served in appropriate settings.⁴ These important elements are reflected in the readiness review tools for each of the six programs we reviewed and also in the final contracts.

Analysis of Contract Responsiveness to Ten Key Contract Elements

The following discussion summarizes how the six duals demonstration contracts and the three non-duals-demonstration contracts each respond to the ten key contract elements. **See the Appendix at <http://clpc.ucsf.edu/file/1716> for contract language referred to in this section.**

1. Policies and procedures that are required to ensure compliance with the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and relevant state law.

Duals demonstration contracts

The Virginia, Illinois, Michigan, Massachusetts, and South Carolina contracts explicitly state that the participating health plan and its network of providers must comply with the Americans with Disabilities Act, and health plans are required to have written policies and procedures to assure compliance. The New York contract does not explicitly call for policies and procedures related to ensuring meaningful compliance with the ADA, but it does call for developing and implementing a strategy to manage the provider network with an emphasis on cultural competence, ADA compliance and accessibility, integration, and cost-effectiveness. Each of the other five contracts focuses on ensuring ADA compliance in slightly different ways. For example the Massachusetts contract calls for ensuring that physical, communication, and programmatic barriers do not inhibit individuals

with disabilities from retaining all covered services. Virginia, on the other hand requires the health plan to demonstrate a commitment to accommodating the physical access and flexible scheduling needs of enrollees. It provides specific examples, such as TTY video relay services, remote interpreting services, and alternative formats/TDD devices for deaf and hard of hearing individuals, qualified American Sign Language interpreters, and cognitively accessible communication for persons with cognitive limitations.

Other contracts

New Mexico and New Jersey each have contract provisions related to disability access policies and procedures. New Mexico calls for policies and procedures related to maintaining a network of appropriate providers and calls for considering the provider's physical access for people with disabilities in terms of distance, travel time, and transportation. The contract also simply passes through responsibility for ADA and Section 504 compliance to the MCO, with little detail about how to accomplish compliance.

New Jersey, on the other hand, includes extensive, robust ADA compliance language, including requiring policies and procedures, a written plan to monitor compliance, and assurance of appropriate physical access for all enrollees including, but not limited to, street-level access or accessible ramp into facilities, access to lavatory, and access to examination rooms. The contract also calls for policies and procedures to include the MCOs' role in ensuring that providers receive available resource information on how to accommodate individuals with disabilities, particularly mobility disabilities, in examination rooms and for examinations. Also to be included in the policies and procedures are methods to accommodate individuals with communication disabilities. As mentioned above, the New Jersey contract calls for use of a survey to determine provider ADA compliance and a provision that requires the plans to indemnify the state from liability arising from ADA violations.

2. Provisions to increase disability awareness and cultural competency among providers, including required disability awareness and competency training of network clinical and other provider staff and assurances that the plan and providers understand the goals of community integration, independent living, and person-centeredness for people with disabilities.

Duals demonstration contracts

Each of the duals demonstration contracts includes language intended to increase disability awareness and cultural competency among providers and calls for some type of training for either plan staff or providers or both. Training topics are spelled out in detail in most plans, though placement of the language varies, and are similar across programs.

Virginia requires that plans manage their provider networks with a focus on the independent living philosophy, cultural competence, community integration and cost-effectiveness. The Virginia contract requires training for interdisciplinary care team members, care coordinators, and medical, behavioral, and LTSS providers on topics including the person-centered planning processes, cultural and disability competencies, ADA compliance, and independent living. The contract also references related topics such as the social model of disability, accessibility and accommodations, recovery, ADA/Olmsted requirements, and wellness principles.

Michigan requires training for enrollee service representatives on topics including use of auxiliary aids and services, such as video relay services, remote interpreting services, and conversion of print materials into alternative formats. The contract also requires that health plan care coordinators have knowledge of person-centered planning, cultural competency, and applicable legal nondiscrimination requirements related to the ADA. Michigan also incorporates these concepts in provisions governing network management. Extensive training for medical, behavioral, and LTSS providers is required on topics including the

social model of disability, accessibility and accommodations, cultural competencies, person-centered planning, awareness of personal prejudices, and barriers to care. Training is also required on more general ADA legal obligations and the meaning of concepts such as medication access and medical equipment access.

The New York contract addresses cultural competency for participating providers in provisions concerning education and training, and also in provisions on participant services. Cultural competency training is to be given to providers during orientation. Individuals providing services to participants are expected to demonstrate sensitivity to culture, including disability culture, and awareness of the independent living philosophy, person-centered planning, and self-determination. The New York contract requires training for the interdisciplinary care team on person-centered planning processes, disability cultural competence, accessibility and accommodations, and on independent living. It also requires provider training on community-based and facility-based LTSS, physical accessibility, accommodations, accessible exam equipment and methods to ensure clear signage.

Illinois includes the principles of independent living, cultural competency, and integration in its overall strategy to manage its provider network. The Illinois contract also requires training for interdisciplinary care team members, care coordinators, and medical, behavioral, and LTSS providers on subjects including person centered planning processes, cultural and disability competencies, ADA compliance, and independent living.

Massachusetts includes references to the independent living philosophy, person centeredness, disability culture and community integration for people with disabilities in several areas of its contract, including its definition of terms, network management, and authorization of LTSS and community-based services. Massachusetts also includes a requirement that enrollee services demonstrate sensitivity to culture, including disability culture and the independent living philosophy. The Massachusetts contract requires extensive

provider education and training involving person-centered planning processes, accessibility and accommodations, and cultural competency. It also requires similar training for the interdisciplinary care team. The Massachusetts contract also requires Personal Assistance Services Network evaluators be trained on the independent living philosophy.

South Carolina includes somewhat detailed references to principles of disability culture and the independent living philosophy in various provisions concerning training for the plan staff as well as for medical, behavioral, and LTSS providers. The South Carolina contract requires training for plan staff on topics that are similar to those required by other contracts. It also requires training for network providers on the social model of disability, ADA compliance, accessibility accommodations, disability literacy, awareness of personal prejudice, physical accessibility, and concepts of communication and medical equipment access.

Other contracts

Both New Mexico and New Jersey have some provisions related to cultural competency. The New Jersey contract permits enrollees with complex disabilities to substitute a specialty physician as their primary care provider. Competency in this context is focused on clinical skill, however, and does not extend to broader disability awareness. The New Jersey contract recognizes communication access such as Sign Language interpretation and TDD services as an integral aspect of cultural and linguistic enrollee needs. New Jersey's contract provides for extensive plan staff and MLTSS staff training, as well as ongoing provider and care manager training that fosters cultural sensitivity. Specific training for health care providers on use of sign language and other language interpreters is also required. New Jersey also tacitly acknowledges the need for alliances with independent living organizations and includes awareness of independent living options as an area of expertise for care managers.

The New Mexico contract defines cultural competency broadly, and calls for a cultural competence and sensitivity plan and provider

training. It also calls for culturally competent services for enrollees with speech and language disorders, such as use of qualified medical sign language interpreters, and for enrollees with physical and developmental disabilities. New Mexico's contract does not contain specific language related to ADA training for either staff or providers or any other type of training applicable to accommodating enrollees with mobility or other sensory or cognitive disabilities.

Minnesota's contract does not mention the principles of independent living, cultural competency, or self direction. It also does not contain specific language related to ADA training for either staff or providers or any other type of training applicable to accommodating enrollees with mobility, sensory, or cognitive disabilities.

3. Provisions related to assuring that beneficiaries receive reasonable accommodation, policy modifications, and auxiliary aids and services when required to ensure equitable and effective care and services.

Duals demonstration contracts

Each of the six duals demonstration contracts includes similar language related to ensuring that physical, communication, and programmatic barriers do not prevent beneficiaries from receiving needed care and services. Each contract provides similar examples of methods to ensure that enrollees have access to services, such as providing flexibility in scheduling, interpreters, large print, assistance filling out forms, using electronic methods for communication, and assuring safe and appropriate physical access to buildings, services, and equipment.

Other contracts

The New Mexico contract calls for policies and procedures on how enrollees can access services, as well as other written member materials to be available in alternative formats. In-person sign language interpretation must be provided as needed and telephonic and telehealth services

must be accessible via TTYs and the Telecommunication Relay Service. Alternative format needs of members must be included in the health records system and member services must be trained to handle calls from hearing impaired members. Plans are barred from requiring that members supply their own interpreters.

New Jersey has similar, but more detailed, requirements that are presented in ADA non-discrimination terms. Policies and procedures are required that document availability of access procedures for services that ensure physical and communication access, including interpreters and TDD services and that require provider training on using interpreters. 24-hour interpreter access is also required.

Minnesota's contract similarly requires that information be provided in alternative formats and that availability of such formats be noted in membership materials. It also requires that information be made available to enrollees on factors such as physical accessibility and availability of interpreter services, other alternative modes of communication, and access to TDDs.

4. Requirement that MCOs assign a specific person responsible for overseeing plan and provider actions aimed at achieving physical and programmatic accessibility of facilities and services and other contracted services.

Duals demonstration contracts

Each of the six duals demonstration contracts includes similar language related to ensuring that a specific person will be assigned responsibility for ensuring physical and programmatic accessibility. Contract language generally assigns responsibility for ADA compliance to a specific individual and does not distinguish tasks this person might undertake related to the operations of the plan as compared with ADA compliance by providers. All six of the contracts indicate that the responsible person must establish and execute, and annually update, a workplan to achieve and maintain ADA compliance.

Other contracts

New Jersey and New Mexico's contract requires a compliance officer with broad oversight authority for applicable state and federal laws that could encompass ADA and related plan obligations. Minnesota, on the other hand, assigns its compliance officer responsibility for oversight primarily of fraud and abuse.

5. Delineation of specific actions required of the health plan itself.

Duals demonstration contracts

Each of the six duals contracts calls for the plan itself to take certain actions related to its own operation as distinguished from actions related to the plan's network of clinical and service providers, which are discussed elsewhere.

For example, South Carolina requires that enrollee service representatives be trained in the use of auxiliary aids and services such as TTY's, video relay services, remote interpreting services and examples of alternative formats. The contract also requires that enrollee service representatives demonstrate an understanding of disability culture and independent living. Moreover, they are also directed to provide reasonable accommodation for beneficiaries with disabilities in order to assure effective communication.

Similarly, the New York and Michigan contracts provide detailed language concerning how member service representatives are to be trained including how to use auxiliary aids and services, provide alternative formats, and otherwise arrange for any required accommodations to ensure effective communication or that may be required to ensure accessibility of information.

Massachusetts takes a different approach by establishing a centralized enrollee record and health information exchange. This provision of the Massachusetts contract requires documentation of physical and programmatic access needs of beneficiaries, including required methods for effective communication and their need for accessible medical equipment. The Massachusetts contract is the only one to call for

documenting the physical and programmatic access needs of beneficiaries.

Among the six duals demonstration contracts, the Illinois contract contains the least detailed language, but it does specifically require the plan to certify that it and its employees will comply with applicable civil rights laws including the ADA and Section 504.

The Virginia contract acknowledges that beneficiaries require written information including notifications, the enrollee handbook and other communication in an accessible format and that the plan must provide such information. The Virginia contract also appears to be the only one that requires that plans provide accessible information technology equipment, software, and websites. These access requirements are contained in state law.

Other contracts

New Mexico's contract calls for ongoing cultural competence training for member services staff and a plan for providing interpretive services for members. New Jersey's contract explicitly calls for plan staff training including MLTSS training, non-discrimination, and ADA compliance. Minnesota's contract requires that the plan provide information in alternative formats, on availability of interpreter services, on other alternative modes of communication, and on factors such as physical accessibility.

6. A requirement that MCOs carry out an on-site accessibility survey of health care provider facilities that includes availability of accessible medical equipment, such as exam tables and weight scales, in individual practices; and a requirement that such surveys not be delegated to network providers to complete.

Duals demonstration contracts

Each of the six contracts refer to demonstrating compliance with the ADA by conducting either an independent survey or site review of facilities for both physical and programmatic accessibility. Only Illinois references an existing Provider Site Assessment Tool, which contains specific

architectural elements such as parking, interior and exterior building elements, office reception area, restrooms, exam rooms, and exam tables and scales. In addition to conducting an independent survey or site review of facilities, Virginia also calls for physical and telephone access to services in order to be fully compliant with the ADA.

Although the New York contract indicates that accessibility of provider facilities can be determined through site visits, confirmation of accessibility is to be made through Provider attestation to ADA accessibility using the ADA Accessibility Attestation Form in conjunction with a random sampling of on-site compliance review. New York's contract requires that all participating providers meet ADA requirements and have assigned ADA attestation form on file with the plan.

Other contracts

New Jersey requires that the plan survey its providers for their compliance with the ADA. Survey attestation is to be kept on file by the contractor and made available for inspection. Minnesota and New Mexico do not have provider on-site inspection requirements.

7. A requirement that MCOs assess the capacity of clinical and service providers to provide accommodations such as ASL interpreters, print materials in alternative, accessible formats, and extended exam time; and a requirement that such surveys may not be delegated to network providers to complete.

Duals demonstration contracts

All of the state contracts other than New York's refer to evaluating programmatic accessibility while conducting an independent survey or a site review of provider facilities. However, none of the contracts specifically define programmatic accessibility. Virginia, Illinois, Massachusetts, and Michigan include a reference to evaluating provider capacity to provide certain accommodations for beneficiaries with disabilities, and all the contracts include somewhere in the contract a list of

accommodations required to ensure compliance with the ADA. These accommodations would be subsumed under the umbrella of programmatic accessibility, even though the term is not clearly spelled out and a detailed list is not provided in reference to surveys or site visits of provider facilities. Michigan requires that current and accurate information concerning network adequacy be provided in its online provider directory on a timely basis. Michigan specifically includes provider compliance with the ADA in terms of physical and communication accessibility, as well as what the contract refers to as other reasonable accommodations.

Other contracts

New Jersey requires that the MCO survey its providers for their compliance with the ADA. The contract references Section 504 and requires access to both programs and facilities, so the assumption is that on-site inspections include a programmatic access element, but that requirement is not spelled out. Minnesota includes detailed requirements that the MCO provide sign language interpreters, but does not specify an assessment of providers for other programmatic access elements. New Mexico calls for a plan for interpretive services, but not specify a requirement to assess providers' other programmatic access capabilities.

8. A requirement that MCOs use a specific accessibility survey tool for on-site evaluation of physical and programmatic accessibility.

Duals demonstration contracts

Only Illinois references an existing access survey instrument, the Provider Site Assessment Tool, which contains specific architectural elements such as parking, interior and exterior building elements, office reception area, restrooms, exam rooms, and exam tables and scales.

The New York contract mentions site visits as a method to assess accessibility compliance with the ADA, but it does not reference surveys as a method of collecting this information.⁵ The primary method that New York uses to collect

physical and programmatic accessibility information is the attestation form, which providers are expected to complete. Although the South Carolina, Massachusetts, Virginia and Michigan contracts refer to independent surveys or site reviews of facilities for both physical and programmatic accessibility, these states do not identify or require use of specific survey tools.

Other contracts

New Jersey requires that plans survey providers for their compliance with the ADA using a standard survey document that will be developed by the State. Survey attestation is to be kept on file and be available for inspection. The Minnesota and New Mexico contracts do not require use of an accessibility survey.

9. A required compliance or other plan that sets forth MCO actions to increase and improve accessibility, such as recruiting additional accessible providers or incentivizing accessibility modifications or equipment purchases when network providers are deemed to be physically inaccessible or do not have accessible medical equipment.

Duals demonstration contracts

The Illinois contract requires development of a detailed workplan to achieve and maintain ADA compliance, as well as a description of how noncompliance will be remedied. New York's contract relies on the attestation forms to ensure ADA accessibility. The MCO is also required to establish and implement mechanisms to ensure that providers comply with access requirements and take corrective action when it is required. South Carolina's and Virginia's contracts require development and implementation of a strategy to manage the provider network, with an emphasis on identifying and tracking improvement goals. The Michigan contract requires the plan to establish and execute a work plan to achieve and maintain ADA compliance. Massachusetts requires the plan to document and monitor deficiencies in physical and programmatic accessibility.

Other contracts

New Jersey's contract calls for written procedures and protocols ensuring plan compliance with the ADA.

10. A required plan for ensuring that members have ready access to full and accurate information on provider accessibility, including availability of accessible medical equipment.

Duals demonstration contracts

Each of the six duals demonstration contracts calls for some level of accessibility information to be included in provider directories. The South Carolina contract requires that the online provider directory and search functionality include information on physical and communications accessibility. The Virginia contract requires that the provider and pharmacy directories include information on whether the provider has specific accommodations for people with physical disabilities, such as wheelchair access, accessible exam rooms and tables, weight scales, bathrooms and stalls, grab bars, and other accessible equipment. It also requires that directories indicate whether or not the provider has on-site sign language interpretation available.

The Michigan and Massachusetts contracts are similar to Virginia's, in that they require that beneficiaries have access to current and accurate information from the online provider directory and that this information include an indication of provider compliance with the ADA in terms of accessible offices, exam rooms, and equipment. They also require that provider directories indicate practitioners with areas of special

expertise in treating people with physical disabilities, chronic illness, HIV/AIDS, sensory disabilities, or serious mental illness. In addition, Massachusetts includes a quality improvement project to understand barriers to health access that beneficiaries experience, such as inaccessible medical equipment, signage, or communication from the plan or providers, inadequate access to appropriate physicians for people with intellectual disabilities, and incomplete or poor care due to negative attitudes about disability and/or recovery from providers.

The New York contract requires the plan to prepare understandable, accessible handbooks for medical, behavioral, community-based and facility based LTSS, and pharmacy services. The manuals are intended to be online reference tools that indicate whether or not providers are accessible for people with physical disabilities, including information about the office, exam rooms, and other equipment. The Illinois contract simply requires that provider and pharmacy directories indicate whether sign language interpretation is available.

Other Medicaid contracts

The New Jersey contract calls for the plan to take steps to promote accessibility of all services offered to enrollees, specifically for individuals with physical and mental disabilities. It calls for enrollees to be given information on a variety of issues, including physical accessibility of providers, how to obtain services during regular hours, how to obtain emergency and after-hours care, how to obtain second opinions, and how to obtain names, qualifications, and titles of the providers responsible for their care.

¹ Website: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FINALCMSCapitatedFinancialAlignmentModelplanguidance.pdf> Accessed November 12, 2016.

² Americans with Disabilities Act (ADA) Attestation, Emblem Health, New York. Website: <http://www.emblemhealth.com/~media/E5F15336973F4016AE652D80ED02FA5C.ashx> Accessed February 5, 2017.

³ Nancy R. Mudrick and Silvia Yee, “Defining Programmatic Access to Healthcare for People with Disabilities,” Disability Rights Education and Defense Fund (DREDF), Berkeley, California, Spring 2007.

⁴ Memorandum of Understanding (MOU) between the Centers for Medicare and Medicaid Services (CMS) and the State of Illinois, regarding a Federal – State Partnership to Test a Capitated Financial Alignment Model for Medicare – Medicaid Enrollees, Illinois Medicare – Medicaid Alignment Initiative. Website: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/ILMOU.pdf> Accessed November 20, 2016.

⁵ New York's Managed Long-Term Care contract includes an appendix entitled New York State Department of Health Guidelines for Compliance with the Federal Americans with Disabilities Act. This document contains an extensive discussion of ADA responsibilities including standards for compliance, suggested methods for compliance, and a description of the substantive content of a compliance plan. However, the duals demonstration contract does not reference these guidelines.