**Final Report Covering the Period February 15, 2014 – September 30, 2015**

**October 30, 2015**

**Background:**

This project sought to improve Health Plan service for people with disabilities by working with up to six Plans helping them to reduce barriers to care and to increase their compliance with the ADA. We did this by:

1. Reviewing Plan policies and procedures and key documents to identify gaps that need to be remedied;
2. Suggesting Modifications for plan materials to provide notice of rights and procedures for accessing assistance and obtaining reasonable accommodations
3. Developing training for plan personnel and providers on accessibility and reasonable accommodations based on the ADA and the 3 way contract.
4. Reviewing methods for determining whether physician and provider practices are accessible and methods for ensuring that enrollees who need this information in order to obtain care have access to it.

The project has also:

1. Identified recommendations and best practices for the State to employ to ensure that physical access to buildings, equipment and services is sufficient. .
2. Developed a webinar (slides attached) for plans and DOH ADA compliance personnel.

**Activities:**

CIDNY contracted with consultant Pauline Yoo in late April 2014, an attorney with more than 15 years experience working on issues of disability rights and access to health care, to provide legal review and analysis for the project.

CIDNY’s team met and prepared a list of plan policy and procedure documents that we would need to review so that we can suggest ways to improve practices. These documents were chosen as a result of our review of the Memorandum of Understanding between CMS and New York State (outlining requirements for the duals demonstration); the Model Contract between New York State and FIDA plans; Readiness Review; the ADA Compliance Guidelines; and the issues raised by our review of health plan ADA Compliance Plan submissions to the State. Using the requirements of CMS and NYSDOH Guidance the MOU we created an Analytic Framework for considering the documents requested and an ADA Checklist.

We requested and received 75 documents of up to 100 pages each from: Agewell; Elderplan; GuildNet; United Health Care and VNSNY Choice.

* AgeWell (May 20, 2014),

Ms. Yoo drafted extensive analyses of each of these documents and identified deficiencies in a number of areas. CIDNY’s team reviewed the analysis and made comments and suggestions for improvement in those areas that show deficiencies. We then shared the analyses with the plans. In instances where specific language modifications were requested, we provided these to the plans.

CIDNY’s team held phone and in person meetings with management-level teams from AgeWell, GuildNet, United Health Care and ElderPlan to discuss these analyses and training needs. Meetings with plans included a review of the materials; detailed discussions of areas where materials were missing or insufficient and, where possible, discussions of solutions to gaps were provided.

CIDNY developed training for Care Managers, “*LEGAL OBLIGATIONS AND BEST PRACTICS FOR WORKING WITH PEOPLE WITH DISABILITIES: A Training for Health Plan Care Managers*.” Our 2 ½ hour training was delivered by CIDNY to Care Managers and Supervisors at Agewell, Guildnet and Elder Plan. We also provided a 2-hour webinar for executives and supervisors for FIDA and MLTC plans at United Health Care nationwide, “*LEGAL OBLIGATIONS AND STRATEGIES FOR WORKING WITH PEOPLE WITH DISABILITIES: A Training for Health Plan Personnel*”. A total of 161 FIDA staff were trained.

CIDNY analyzed the State’s provider ADA compliance attestation form. It researched approaches adopted and forms in other states, and from the Department of Justice and other sources and provided these alternate approaches to DOH and CMS.

We were invited to present on our project and findings to a national audience of consumer advocates for dual eligible initiatives. Advocates requested that we supply them with all materials produced pursuant to the project so that they may use these materials in their States.

**Outcomes, Analysis and Interpretation**

**Project Challenges and Revisions:**

1. Plan participation in the project is voluntary. Plans do not believe that they are compelled by the State to participate in improving their ADA compliance on a voluntary basis.
2. Plans experience that they are inundated with changing requirements related to FIDA implementation. State requirements change, CMS has indicated that it plans to introduce new tools related to provider accessibility. Plans feel that they cannot finalize materials given changing requirements.
3. Providers are resistant to participation in training.
4. Plans received numerous templates from the State that do not adequately capture or identify ADA requirements, but they believe they are doing what is required by the State when they merely mimic the State’s language. Thus their ADA policies and procedures may not necessarily reflect plan functioning—rather they reflect what the State has told them they need to write down.
5. Two plans dropped out of the process entirely without notice, without providing a reason for ceasing contact. Two required confidentiality agreements be signed.
6. With one exception, the plans that continued to work with us would only provide CIDNY trainings to care managers and their supervisors. Plans do not feel compelled to provide CIDNY trainings to other staff.
7. Providers in FIDA plans do not feel compelled to take part in IDT’s, to meet ADA requirements for accommodations or to work with plans on providing information to members.
8. At present, while the NYS DOH has advised providers of their obligations pursuant to the ADA, it has no surveillance and enforcement mechanisms to identify whether providers comply with the ADA.
9. While Lewin says thousands have taken the provider training, which includes some disability literacy and ADA compliance information developed by CIDNY, the CMS is considering not requiring provider to take this training, so it is unclear whether providers will continue to do so.
10. One plan indicated that because they are national in scope they cannot adapt their policies and procedures easily to State requirements and only wanted training for their national management level staff.
11. In the FIDA model, much responsibility rests with Care Managers and Nurse Evaluators to assess the need for and grant reasonable accommodations and policy modifications and to ensure that other actors (providers, other plan personnel, etc.) comply. However, it does not appear that these parties have the authority within the plan model to be successful in doing this.

**Some Positive News & Promising Practices**

1. After an initial meeting, one of the plans agreed that they should and could incorporate changes to their initial assessment forms to help care managers and others better identify reasonable accommodation needs of members. They asked CIDNY to provide specific guidance on these changes, which we did. This plan did add a supplemental set of ADA questions to the UAS to enable it to identify functional needs and reasonable accommodations that are recorded for everyone who uses the member file.
2. After training for plan care manager supervisors, one plan told us they would review best practices and how staff at each member contact point (call centers; eligibility determination staff; supervisors; public relations/new member communications staff, etc) understood providing reasonable accommodations and alternate formats. They agreed that training for staff other than care managers would be important to ensure that members with disabilities understood their rights and were able to identify any accommodation needs. They also agreed that it would be advisable to use icons to denote accessibility issues in their member materials – including the provider directory would be helpful for both members and staff.
3. One plan’s policy for participants identifies the right to reasonable accommodations and the right to appeal any decision on accommodations that the member disagrees with. These rights are given to participants annually in standard materials. Participants are also informed of their right to reasonable accommodations during the initial assessment and care planning process.
4. Some plans training materials include information on barriers to care faced by people with disabilities, although they do not include non-physical or non-sensory disabilities. We encouraged these plans to include invisible disabilities, including cognitive and psychiatric disabilities. We provided examples, however cannot state with certainty that they will implement these changes. This is a persistent problem that looms large, given the composition of the population.
5. One plan included the ADA requirements for reasonable accommodations in their provider guidance including a relatively specific and broad list of accommodations that should be available to patients with disabilities. This plan also included information on communication issues beyond ASL, Braille and TTY. They indicated that this is a non-exclusive list.

**ADA Compliance Project: Results and Conclusions**

As we reviewed materials from Member Handbooks, we found issues that indicate a lack of understanding of how the Americans with Disabilities Act (ADA) and reasonable accommodations should be integrated into the plans’ operations. All materials given to members that describe member services and programs must include the right to accommodations and information about access for people with disabilities. FIDA call centers must have mechanisms to comply with the ADA for individuals with speech, hearing and communication needs.

**Recommendations:**

1. **Plans must include specific and easy to understand information on ADA rights and reasonable accommodations and how to get them as part of their member handbook. These should give examples of disabilities that are not exclusive and examples of accommodations including those relating to people with cognitive and mental disabilities. It should also be clear that this is a non-exclusive list and that accommodations must be effective for the individual. The State’s model handbook should provide this language.**

Of the 7 plans we looked at, 5 sent us all or part of their member handbook and none of the 5 plans’ member materials include specific information on the right to reasonable accommodations, how to obtain them and grievance procedures if they feel the plan rejected a reasonable accommodation. Where there is mention of alternate formats or help available, the information is limited to people with physical or sensory disabilities (i.e., you can receive material in Braille, Large print or other alternate formats).

1. **Plans must include specific and easy to understand information on ADA rights and reasonable accommodations and how to get them as part of their website information. Web sites must be tested for accessibility for individuals who use screen readers.**

As with information in member handbooks, materials on plan websites do not have specific information on members’ rights under the ADA, reasonable accommodations and grievance procedures. In some cases, while some information exists on alternate formats, information on how to request them or what other accommodations are available is not specific.

1. **Staff at all points of member contact should be trained on ADA requirements and reasonable accommodations so that they can capture member needs and respond to them. The training should include scenarios reflecting common barriers and reasonable accommodations or policy modifications that may be necessary to ensure access.**
2. **Plans should have tracking mechanisms so that when a reasonable accommodation is identified for a member, it appears on member records so that the member does not have to continually ask for the accommodation.**
3. **The State’s model documents and forms, such as the UAS, should ask for information about functional needs and correspondingly reflect any reasonable accommodations needed.**

The State approved the use of the United Assessment System (UAS) as an intake form, however, the UAS does not adequately capture the accommodation needs of people with disabilities that plans and providers are required to provide. The focus of the UAS is on independent living in the home (obstacle removal). It does not capture information on accommodation needs when traveling or at provider appointments, etc., therefore supplementary information is needed. The UAS also does not capture accommodation needs for people with cognitive, communication, emotional or psychiatric disabilities, for example the need for assistance in completing documents, the need for flexible appointment scheduling, etc.

1. **The State and/or CMS should devise a method for surveying providers for policy modifications and reasonable accommodations they are required to provide pursuant to the ADA. This should not be limited to physical disabilities. There must be a mechanism for correcting and updating information that is inaccurate.**

Currently plans are using a “self-attestation” form that simply asks providers to attest that their offices are, in some limited ways, physically accessible. There is no specific information that asks providers if their equipment (exam tables/medical equipment) is accessible; accommodations in elevators other than Braille; no indication that providers offer flexible appointments, large print materials, additional time for individuals with communication-related disabilities, explanations of complex information, interpreter services, a quiet space for those who require it because of their disabilities, etc. Information is unaudited and no method has been established for updating and correcting provider information that is inaccurate.

1. **The State and CMS should work with their coordinating Civil Rights offices for implementation and enforcement of ADA requirements.**

**CIDNY Training for FIDA Staff: Results and Conclusions**

CIDNY originally contacted seven plans that provided FIDA: Agewell, Elderplan, ElderServe; Guildnet, United Health Care, VNSNY Choice, and Wellcare. Agewell, Elderplan, Guildnet, VNSNY Choice, and United Health Care sent documents for review. All but VNSNY Choice continued to work with us and agreed to some training.

CIDNY developed training for Care Managers, “*LEGAL OBLIGATIONS AND BEST PRACTICS FOR WORKING WITH PEOPLE WITH DISABILITIES: A Training For Health Plan Care Managers*.” Our 2 ½ hour training was delivered by CIDNY to Care Managers and Supervisors at Agewell, Guildnet and Elder Plan. We also provided a 2-hour webinar for executives and supervisors for FIDA and MLTC plans at United Health Care nationwide, “*LEGAL OBLIGATIONS AND STRATEGIES FOR WORKING WITH PEOPLE WITH DISABILITIES: A Training For Health Plan Personnel*”. While this training was developed for a national audience, we used New York State FIDA regulations as examples of best practices, since many will also be following with FIDAs in their states. A total of 161 FIDA staff were trained by CIDNY.

Our trainings were meant to supplement not replace trainings on disability and the ADA that should be performed by the FIDA plans. Each CIDNY training provides information on the laws applying to plans and their staff; background on disability awareness and accommodations, and person centered care. The trainings include experiential components that allow participants to practice strategies under facilitation by our trainers. These exercises provide a safe venue for staff to explore their knowledge of disability, accommodations and the law, while developing skill in working with people with disabilities.

Each plan trained was given a power point and handouts for their use with new staff and with other staff as they saw fit. We provided Train-the-trainer power points training for Guildnet, who only wanted their trainer trained.

Since New York had over 20 plans participating in FIDA, the state and CMS convened a FIDA Provider Training Workgroup to develop training modules for FIDA Providers to take using an on-line portal developed by Lewin. CIDNY served as a consumer representative to this workgroup and helped develop the overview module. We also provided content for and made extensive revisions to ADA module. Due to resistance by providers, CMS modified the training requirements to limit it to IDT members and is now considering making it optional; however Lewin reports that 1,000s of providers have taken the training that includes our components. In addition, CMS is contemplating how this workgroup can use the ADA attestation information to improve provider directories. Since this information is unaudited, CIDNY has recommended that a method be devised for correcting and updating the information when consumers find it to be inaccurate.

**Recommendations on Training for Plan Staff**

1. **Plans should train care managers on all types of disabilities** **and on their obligations under the ADA**. While all three plans say they train care managers on the ADA, care managers still have difficulty understanding disabilities that are not physical or sensory and accommodations for people with non-mobility or non-sensory disabilities. For example, most care managers were not able to easily identify accommodations for people with cognitive, emotional or psychiatric disabilities. While much of the plans’ training identify the ADA and Olmstead as laws that apply to their activities, these definitions are not integrated into context of their work with members, so care managers don’t necessarily understand when and how the ADA and Olmstead apply to their work.
2. **Plans should spend more time training care managers on accommodations and access to care**. Care managers should have the authority to negotiate reasonable accommodations.
	1. **Many care managers did not understand that providing accommodations for members did not supplant or eliminate other rights, such as right to self-determination, self-direction and privacy.** Many care managers in our training seemed to view accommodations and working with members on issues related to access to care as part of the medical system rather than as a civil rights requirement of the ADA. For example: they have difficulty with the idea that people with cognitive or psychiatric disabilities can be capable of making their own decisions about care or about their accommodations.

Even with a scenario where the member was saying that they were having difficulty understanding instructions or materials, the care managers’ first response was to talk to someone else about what to do to accommodate the member. They did not start by working directly with the member to ask further questions about how best to accommodate them. Many of the care managers said they would call the provider first to check what the member told them.

* 1. **Many care managers did not understand the interactive nature of the accommodation process with the member.** Many care managers also seem to feel that they should develop the solution to any problem without talking to the member first to see what the member believes he/she needs. More training should also be done on person-centered care, what that means and how managers can care work with members to resolve accommodations and access issues.
	2. **Care managers need better training to understand the plan’s own accommodations process and their role in it.** As key players in the Interdisciplinary Team responsible for a member’s care and accommodations, the care managers need to have a better understanding of how to assess the need for and how to arrange for accommodations. In our trainings, care managers often did not know crucial information, such as how to arrange for American Sign Language interpretation and the obligations of providers to provide that or other accommodations. For example, some care managers seem to either have sympathy about “the doctor’s side of things” or feel that doctors are uncooperative for most things – their reaction to some of our scenarios with problems with doctors was simply to change doctors rather than trying to help educate doctors and their staff about their obligations and then to proceed to obtain the accommodations with those doctors. At one training, several people noted that the providers might have trouble with accommodations, and that, “Small providers might not have ASL interpreters on staff…”, “if there’s an issue with a member having trouble at the providers’ office, I’d see if a family member could go with them.” These strategies will not result in members obtaining the reasonable accommodations they have a right to and will leave barriers to care in place.

**Care managers need to be trained that the plan as well as providers are subject to the ADA accommodations requirements.** For example, when presented with a scenario where the member was saying that they were having difficulty understanding instructions or materials, care managers did not understand that they should report problems with instructions or materials to the plan so that better formatting or alternative ways of communicating could be instituted plan-wide.

1. **Plans should train staff at all points of contact on how to ask about accommodation needs using the** ADA definition and **American Community Survey Disability Questions.** Supervisors and care managers were a little unsure of how other departments were tracking accommodations. Call Center staff are supposed to be trained, but often do not identify or track accommodation needs. Many care managers said that the UAS took care of that, but we know from experience that the UAS questions are not sufficient. Only one plan had added a supplementary questionnaire to the UAS. Members may have to wait until the initial visit is done before they receive necessary accommodations – particularly difficult for those who need communication accommodations. Also since most “visits” by care managers are done by phone, it becomes even more critical that the care managers use clear easy questions to identify needs beyond medical needs. Moreover, the wait until the initial visit fails to identify when the member may need an accommodation in communicating with the plan, even for the initial visit.
2. **Plans should develop tracking/feedback mechanisms for accommodation or access issues with providers in the plan**. Plans should use feedback and incidences from care managers who encounter problems or resistance from providers as part of their regular training to help care managers develop strategies to resolve problems rather than having a supervisor intervene, if possible. Care managers should also be able to act on ADA non-compliance by plan providers. During the problem solving portion of the training, care managers were empowered by the idea that they could tell providers about their responsibilities to members under the law – i.e., that providers were responsible to provide ASL for members who are Deaf, that they should negotiate reasonable accommodations for members who have disabilities and that is their responsibility under the ADA.

The plan also can use the tracking mechanism to ensure that the provider network is ADA-compliant. Tracking whether the providers are compliant allows the plan to track whether the plan has enough providers that will and can adequately serve people with disabilities.

**Communications and Dissemination**

For CMS and New York State DOH, CIDNY produced a matrix comparing provider ADA compliance approaches adopted by the Department of Justice, the State of California, and a variety of other ADA experts. This matrix has resulted in a modification of the CMS approach to informing plan enrollees about accessibility at provider offices, further modifications are anticipated.

CIDNY produced a list of health plan policy and procedure documents that should be examined and modified to reflect the plans methods for complying with the ADA.

Five training power points were produced including a training for health plan executives; a CIDNY Best Practices Training, a Train the Trainer training, a training for Care Managers, and a training for advocates.

Future plans include a page on our web site for advocates, plans and regulators, “Resources for Improving Health Plan Services for People with Disabilities” which will include these recommendations and all materials.

We are sending these materials and recommendations to CMS and to the New York State Department of Health. We will continue to advocate for improvements to ADA compliance in the FIDA demonstration.