Issue Brief
Improving Health Care Access for People With Disabilities

People with disabilities building community
THE INDEPENDENCE CENTER

The Problem

As the Centers for Disease Control asserts, you can have a disability and be in good health. But practically speaking, it doesn't happen nearly enough. Twenty-seven years after passage of the Americans with Disabilities Act (ADA), health care stands as the only U.S. economic sector that has fully escaped ADA compliance.

Hundreds of thousands of Coloradans with disabilities receive substandard care — if they receive care at all. If you have a "functional limitation" related to mobility, speech, vision or hearing, many doctors' offices can not accommodate you. Where you can get in the door, you probably won't find an adaptive exam table or X-ray equipment, or even a scale. Nor will you find employees trained in serving patients with disabilities. There are exceptions, but no easy way to locate one.

This creates a cascading effect, where at the bottom you find both declining health and increasing costs. Studies show that many people with disabilities seek and receive only catastrophic care, not preventive care — which helps explain why the state says they represent 7 percent of Colorado's total Medicaid enrollment but 27 percent of its expenditures. (Colorado Medicaid Fiscal Year 2015-16 Data, Presentation to Joint Budget Committee, Jan. 3, 2017.)

People with disabilities make up more than 20 percent of the U.S. population. And as we age, most of us will acquire a functional limitation. This is why access to health care doesn't just mean having a doctor's office nearby. Physical accessibility is one of three pillars of the ADA; the others are programmatic accessibility and effective communications. This has been the law for more than a quarter-century; it is past time for Colorado's health care community to respond.

Medical Accessibility, LLC www.medicalaccessibility.com

The Background

Even before the ADA's 1990 passage, Section 504 of the Rehabilitation Act of 1973 prohibited discrimination against people with disabilities in everyday activities — including receipt of medical care. As explained in a 2010 memo from the U.S. Department of Justice and the Department of Health and Human Services, both the ADA and Section 504 require that providers offer "full and equal access" to health care services and facilities, as well as make "reasonable modifications to policies, practices and procedures," for those with disabilities.

The medical community's failure to adhere is no secret. In 2013, the New York Times reported on a group of researchers who called more than 250 doctors of various specialties, in four major U.S. cities, on behalf of a fictional patient. When told this "patient" was partly paralyzed, needed assistance to exit a wheelchair, weighed about 200 pounds, and sought a specialized medical evaluation, fewer than 10 percent of doctors had sufficient equipment and employee training to handle the patient. One in five wouldn't even book an appointment.

In the ADA's early days, many providers could reasonably claim that they couldn't afford to become fully accessible. But accessible technology keeps improving, and related costs keep dropping.

Today there is equipment like the "Upscale," an exam table that raises and lowers; weighs a patient in a resting position; and includes stirrups for gynecological exams. At $5,000 per table, that's on the high end of access expenses. "Hearing loops," which transmit a doctor's words via a microphone and magnetic field to patients' hearing aids, can be installed for only a few hundred dollars. Medication bottles that "talk" to patients who are blind cost less than $50. And small providers incurring expenses for ADA compliance may be able to claim the Disabled Access Credit and/or tax deductions.

Without accommodations — or knowledge of where such accommodations exist — people with disabilities often simply stop seeing doctors until it's time for an expensive emergency room visit. According to 2008 National Center for Health Statistics data, 74 percent of women without a disability had received a mammogram in the previous two years, and 83 percent had received a pap test in the previous three years. Among women with movement difficulties, those percentages dropped to 66 and 68, respectively. Numbers fell further among women with seeing/hearing, emotional or cognitive disabilities.

Local advocates have led efforts to improve the situation. In 2014, The Independence Center and other disability organizations wrote protocols to help the state Medicaid system (Colorado's Department of Health Care Policy and Financing) better serve people qualifying for both Medicare and Medicaid. Those protocols were implemented into the state's contract language with the federal Centers for Medicare & Medicaid Services (CMS). But today, no one ensures that they are followed.

No one expects every doctor's office to upgrade all its architecture, equipment and training procedures. The concept of "network adequacy" anchors the new Medicaid and Children's Health Insurance Program Managed Care Final Rule. It explains that not every physician and specialist needs to fully accommodate people with disabilities — instead, states must ensure that every region contains an adequate number who do. The rule also requires similar access to programmatic services and information about compliant facilities.

This is a step — but only a step. Currently, proposed language for Colorado's 2017 rebid process would require the state Medicaid system to "make a good faith effort to achieve" network adequacy for seniors and people with disabilities. As of this writing, it remains unclear what a "good faith effort" entails.

A CALL TO ACTION

Our health care community basically includes two groups of providers: those primarily serving people with private insurance, and those serving people on Medicaid and/or Medicare. We strongly encourage both groups to give greater priority to disability-friendly care. But we are concentrating our efforts on the latter, given that these patients tend to have greater health care needs and fewer health care choices.

When the state Medicaid system solicits new bids, would-be providers should be contractually required to demonstrate network adequacy across all three ADA pillars. The state and CMS have already approved an assessment tool to divide state medical offices, clinics and diagnostic centers into three priorities:

1. those fully accessible to Medicaid-Medicare patients;

2. those that, with relatively minor improvements, would be able and willing to serve such patients;

3. and those for which compliance is not "readily achievable."

We are proposing that the state Medicaid system be given 18 months to identify barriers and create a plan for transitioning medical facilities from priority 2 into compliance. The system would then have five years to fund and make physical, programmatic and communication-related accommodations. As accommodation data became available, the Medicaid System would publish contact information for accessible medical services via a Section 508-accessible website, social media and print, and also make the information available at customer care call centers.

Care providers serving Medicaid and Medicare patients have long been treated with kid gloves. With federal reimbursement rates well below those of private insurance companies, there is always the risk that yet another doctor will simply stop accepting these patients, further reducing options for those with disabilities.

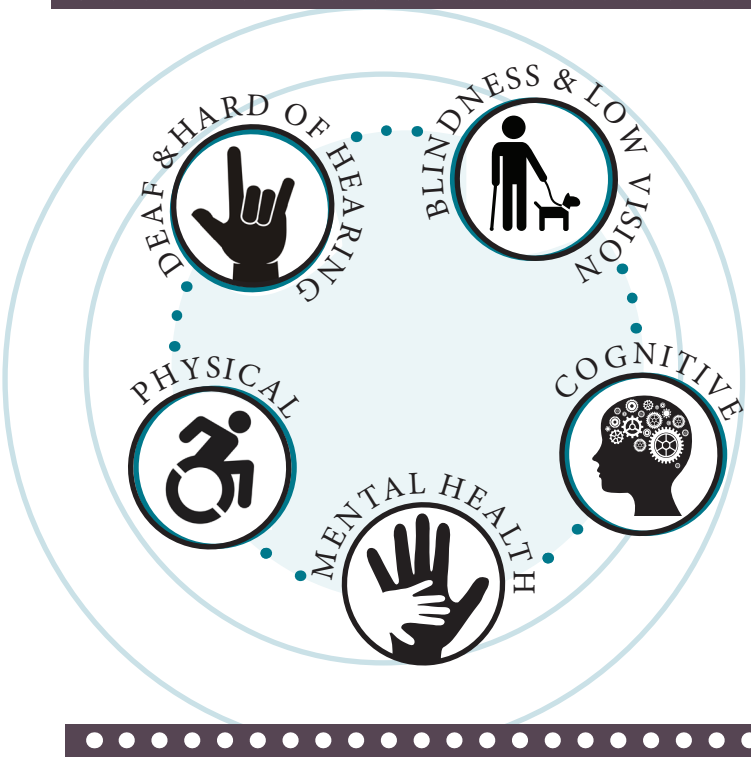
But something must give. American Community Survey data shows more than 550,000 Coloradans with disabilities. With rising incidences of autism, asthma and childhood obesity, disability rates will likely increase

among young people. At the other end of the spectrum, Coloradans now live for an average of 80 years — and more than 70 percent of those 80-plus have a functional limitation. Frankly, to prevent worsening of conditions or development of secondary conditions, we cannot afford not to treat people with disabilities early and as needed.

A 30-something woman shouldn't receive a dosage "guesstimate" for chemotherapy because her doctor can't weigh her in her wheelchair. A 75-year-old man with hearing loss shouldn't get a less thorough physical exam because communicating with him takes more time. And neither should wind up generating ER bills after giving up on receiving adequate preventative care from their doctor. People with disabilities — whether born with them or having acquired them over time — have a right to the same good health as anyone else. Colorado has already conceived innovative and well-regarded policy changes. It is time to seize the opportunity to lead on this issue.

Maxi-Aids 1-800-522-6294, www.maxiaids.com

WHAT
TYPES OF DISABILITIES?



The Independence Center is one of the nine CILs in Colorado and is located in Colorado Springs. The IC serves El Paso, Teller, Park, Lincoln, Cheyenne and Kit Carson counties. In addition to providing Independent Living Services in the community, The Independence Center also operates a Home Health program, funded by Medicaid that allows us to pay for personal services in the home to prevent institutionalization.

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