DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES

DATE: August 30, 2017

TO: All Medicare Advantage Organizations, Prescription Drug Plans, Program of All-inclusive Care for the Elderly ("PACE") Organizations, Medicare-Medicaid Plans, and Section 1876 Cost Plans

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SUBJECT: Frequently Asked Questions Regarding Accessible Communications for Individuals with Disabilities, Pursuant to Section 504 of the Rehabilitation Act of 1973 (Section 504) and Section 1557 of the Affordable Care Act (Section 1557)

This Memorandum provides responses to questions CMS has received from Medicare Health and Prescription Drug Plans about accessible communications for individuals with disabilities. If you have additional questions about compliance with Section 504 and accessibility as it relates to communications for individuals with disabilities, please contact your CMS Account Manager, who may coordinate with the Offices of Hearings and Inquiries' Customer Accessibility Resource Staff as needed, to provide you with a response.

Pursuant to the August 25, 2016, HPMS email regarding questions with respect to Section 1557 that do *not* concern accessibility in communications for disabled individuals, Medicare Plans should contact the Department of Health & Human Services' Office for Civil Rights ("HHS' OCR") at 1557@hhs.gov. Please also feel free to access OCR's *Frequently Asked Questions* relating to Section 1557 at https://www.hhs.gov/civil-rights/for-individuals/section-1557/faqs/index.html

FREQUENTLY ASKED QUESTIONS REGARDING ACCESSIBLE COMMUNICATIONS

1. Are Medicare Advantage Organizations, Prescription Drug Plans, PACE Organizations, Medicare-Medicaid Plans, and Section 1876 Cost Plans (hereinafter referred to as "Medicare Plans" or "Medicare Plan") required to comply with Section 504 (and the provisions relevant to non-discrimination based on disability established by Section 1557; implemented by 45 C.F.R. Part 92)?

RESPONSE: Yes.

2. Do Medicare Plans have to give notice that, upon request, they will provide communications and publications in alternate formats?

RESPONSE: Yes. Medicare Plans can fulfill this requirement by complying with 45 C.F.R. § 92.8. Each Medicare Plan must take steps to notify beneficiaries, enrollees, applicants, and members of the public of the following:

(1) The Medicare Plan does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities;
(2) The Medicare Plan provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities;
(3) How to obtain the aids and services from the Medicare Plan;
(4) If the Medicare Plan has 15 or more employees:
    a. The identification of, and contact information for, the responsible employee or employees designated to coordinate requests for communications in alternate formats;
    b. The availability of the grievance procedure and how to file a grievance; and
(5) How to file a discrimination complaint with the HHS' OCR.

In an effort to support individuals and Medicare Plans, CMS is also encouraging Medicare Plans to provide notice to individuals that complaints relating to a disabled individual's access to information can be filed with CMS. *See* FAQ no. 12 *below* for more information. This is to ensure that CMS has an opportunity to work with the parties involved to achieve the most expeditious and effective outcome.

See also 81 Fed. Reg. at 31,472-31,473 (May 18, 2016) for the following sample Notice and Statement, relating to 45 C.F.R. Part 92, and accessibility requirements not relating to disabled individuals (and a sample language assistance services tagline):

- The longer *Notice Informing Individuals About Nondiscrimination and Accessibility Requirements* (referred to as the "Notice" throughout this document);
- The shorter *Nondiscrimination Statement for Significant Publications and Significant Communications that are Small-Size* (referred to as the "Statement" throughout this document); and

- The tagline for informing individuals with limited English proficiency, of language assistance services.

These FAQs address the notice and statement as they relate to individuals with disabilities and do not address the language taglines.

Pursuant to 45 C.F.R. § 92.8, Medicare Plans must also post a notice (the sample Notice may be used for this purpose) regarding non-discrimination (and the language taglines). Each Medicare Plan must post the notice described above in a conspicuously-visible font size as follows:

> (i) In significant publications and significant communications targeted to beneficiaries, enrollees, applicants, and members of the public, except for significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures;
>
> (ii) In conspicuous physical locations where the Medicare Plan interacts with the public; and
>
> (iii) In a conspicuous location on the Medicare Plan's Web site accessible from the home page of the Medicare Plan's Web site.

Of course, a Medicare Plan may also post the notice in additional publications, communications and forums. CMS encourages Medicare Plans to actively promote accessibility.

For significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures, Medicare Plans must include in a conspicuously-visible font size the statement that the Medicare Plan does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities. The sample Statement provided by HHS' OCR states the following:

Nondiscrimination Statement for Significant Publications and

Significant Communications that are a Small Size:

> [Name of covered entity] complies with applicable Federal civil rights laws, and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

For more information, including information relating to language access, *see* 81 Fed. Reg. at 31,472-31,473; 45 C.F.R. Part 92. In addition, a Medicare Plan may combine the content of the notice with the content of other notices if the combined notice clearly informs individuals of their civil rights under Section 1557 of the Affordable Care Act, and its implementing regulations, which relies in part on Section 504 requirements.

3. Does a Medicare Plan just have to give the applicable notice once or is it an ongoing duty?

RESPONSE: It is a continuing responsibility to give the applicable notice. *See* 45 C.F.R. §§84.8 and 92.8.

4. In what language must the notice, and the shorter statement, be given?

RESPONSE: Pursuant to HHS' OCR's Section 1557 FAQs, the notice and statement must be provided in English. *See:* https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html

As clarified previously, questions relating to 45 C.F.R. Part 92 not relating to communicating with individuals with disabilities should be directed to HHS' OCR at 1557@hhs.gov. Please copy your CMS account manager so that your account manager can coordinate with OHI's CARS.

5. If a Medicare Plan's existing stock of hard copy materials does not have the necessary notices or statements required by 45 C.F.R. Part 92, can the Medicare Plan still use the materials?

RESPONSE: Yes. For hard copy materials that were printed before the effective date of the Section 1557 regulation (July 18, 2016), Medicare Plans may exhaust existing stock. Please note that enclosing an insert of the required notice and statements with the publication or communication complies with Section 1557 requirements.

6. What are "significant publications and significant communications"?

RESPONSE: Please see HHS' OCR's *Section 1557: Frequently Asked Questions* at https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html.

7. Do Medicare Plans have to have the same menu of alternate formats for print materials available to their enrollees, applicants, and members of the public, including potential enrollees, that CMS has available?

RESPONSE: No. A Medicare Plan must have a timely process for adjudicating enrollees', applicants', and members' of the public requests, giving weight to each individual's request. A Medicare Plan could have a menu of alternate formats for print materials available that is likely to address what the Medicare Plan believes will be a majority of requests for alternate formats based on CMS' menu, data applicable to the Medicare Plan's service area(s), or the Medicare Plan's experience. As an example, CMS currently offers a variety of alternate formats for print materials such as Large Print (18-point font), Braille, Data CD, and Audio CD.

CMS also employs a process to timely adjudicate requests for communications in alternate formats that are not included in this menu, and offers Video Relay and TTY services for the hearing impaired.

The process a Medicare Plan may develop to adjudicate all requests for communications in an alternate format must be timely. In order to minimize burden, a Medicare Plan could ask an enrollee that they know to be an individual with a disability if future communications should be provided in an accessible format, and ask which accessible format. A Medicare Plan could then capture the enrollee's preference so that the enrollee would not need to make the request more than once regarding communications from that Plan.

8. Does a Medicare Plan need to have a process by which it can receive incoming communications from disabled individuals requiring an alternate format?

RESPONSE: Yes. A Medicare Plan must take appropriate steps to ensure communications with disabled individuals are as effective as communications with others in health programs and activities. Medicare Plans receive incoming communications from fully-abled individuals so in order for plans to be compliant with 45 C.F.R. §92.202, they must be able to receive incoming communications from disabled individuals. Examples include Video Relay Services and TTY.

9. Must a Medicare Plan's Web site and other electronic communications be in a format that allows disabled individuals access to the Medicare Plan's information?

RESPONSE: Yes. Medicare Plans must ensure that a beneficiary can access and use the Medicare Plan's electronic means of communications such as the Plan's Web site. In order to be compliant with 45 C.F.R.§§92.202 and 204, the Medicare Plan should test the Web page to ensure that, for example, the screen reader can read the text in an understandable way. It is important that headings and bodies of text are identified by the screen reader as such, and that the accessibility format is supported by the various web platforms such as iOS, Google, etc.

If a Medicare Plan determines that an individual's request would impose undue financial and administrative burdens or would cause a fundamental alteration in the nature of a service, program, or activity, the Medicare Plan must, to the maximum extent possible, ensure that the individual receives the benefits or services of the Medicare Plan that would have otherwise been provided through the electronic and information technology. As stated, elsewhere in these FAQs, HHS' OCR and CMS will view the *undue-burden* and *fundamental-alteration* standards as very high standards.

10. Is a Medicare Plan required to have an online appointment system?

RESPONSE: Medicare Plans, or their providers, are not required to have, an online appointment system solely for the purpose of serving disabled individuals. However, should a Medicare Plan, or its providers, have and utilize one or more of these systems, it should ensure that individuals with disabilities can access and utilize these systems.

11. Does a Medicare Plan need a process by which a request for an alternate format can be adjudicated?

RESPONSE: Yes, a Medicare Plan must have a process by which it can adjudicate requests for alternate formats in a timely manner. The Medicare Plan may deny a request if it determines that the request would fundamentally change the nature of the benefit, would result in undue financial and administrative burdens, or that the request is for an individually-prescribed device (such as a reader for personal use or study) or a device of a personal nature (such as a compact disc player to listen to a provided audio CD). These are very high standards. A Medicare Plan may also deny a request for a specific format on the basis that another effective means of communication with the given individual exists, giving weight to the individual's ability to understand the other means of communication. Even if the Medicare Plan denies a request, it must ensure that, to the maximum

extent possible, the Medicare Plan is able to communicate effectively with the individual such that he/she receives the benefits and services of the Medicare Plan. *See generally* 45 C.F.R. § 92.202.

If a Medicare Plan denies a request, the Medicare Plan should document its decision and be able to produce it to CMS and/or HHS' OCR upon request. If CMS and/or HHS' OCR reviews a Medicare Plan's decision, it will give weight to the individual's request, and will view the *Burden* and *Nature-of-Benefit* standards as very high standards. Furthermore, the *Another-Effective-Means-of-Communication-Exists* standard does not include asking the disabled individual to have another individual read the document on the disabled individual's behalf (with the exception of a qualified reader provided by the Medicare Plan).

If a Medicare Plan denies a request, the Medicare Plan must provide the individual with information in a format reasonably likely to be understood by the individual on how to file a grievance with the Medicare Plan as well as to remind the individual about the right to file a complaint with HHS' OCR and be given information on how to do so. CMS encourages Medicare Plans to provide information on how to file a complaint with CMS. The individual does not need to exhaust the Medicare Plan's process before filing a complaint with CMS and/or HHS' OCR.

Individuals may contact CMS directly when their complaints are not resolved by the Medicare Plan, or if they believe their complaint was not resolved correctly. The individual may file a complaint with CMS by doing one of the following:

a. Calling 1-844-ALT-FORM (1-844-258-3676). TTY users should call 1-844-716-3676;
b. Sending a fax to 1-844-530-3676;
c. Sending an email to AltFormatRequest@cms.hhs.gov; or
d. Sending a letter to: Centers for Medicare & Medicaid Services Offices of Hearings and Inquiries 7500 Security Boulevard, Room S1-13-25 Baltimore, MD 21244-1850 Attn: CMS Customer Accessibility Resource Staff.

CMS expects individuals to file the complaint within 180 calendar days of the alleged discrimination.

An individual can also file a complaint of discrimination with HHS' OCR electronically through its Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201. Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

12. Must an individual receive a final determination from the Medicare Plan, before the individual files a complaint with CMS and/or HHS' OCR?

RESPONSE: No. If an individual files a complaint with CMS before s/he receives a determination from the Medicare Plan regarding the individual's request for an alternate format, CMS will attempt to coordinate with the Medicare Plan before CMS renders a decision. This could occur when an individual believes that the Medicare Plan has not made a determination in a timely manner.

Once the individual receives a determination from the Medicare Plan, ideally, individuals will work through the Medicare Plan's grievance process first to come to a mutually agreeable solution. Having said this, none of the complaint/grievance processes are exclusive of the others, and an individual need not exhaust a given complaint/grievance process before filing a complaint/grievance via another of the mentioned processes. While not optimal, an individual may file a complaint/grievance via all three avenues without a final determination from another of the complaint/grievance processes. HHS' OCR, CMS, and the applicable Medicare Plan should coordinate on duplicate complaints to ensure the appropriate resolution is implemented.

If a Medicare Plan receives a grievance from an individual pursuant to the process required under 45 C.F.R. §92.7(b), it should make its CMS Account Manager aware so that the Account Manager can contact CMS' CARS to determine if a duplicate complaint has been filed with CMS or HHS' OCR.

13. If an enrollee indicates a preference for an alternate format on an enrollment application, must the Medicare Plan provide future materials in that format?

RESPONSE: The Medicare Plan must make best efforts to provide future materials in an accessible format.

14. Will an enrollee have to make a request for alternate formatting each time the enrollee wants to receive a communication in an alternate format?

RESPONSE: Enrollees with disabilities must have an equal opportunity to participate in a Medicare Plan's benefit. Therefore, a Medicare Plan must make a best effort to ensure that an enrollee need only make the request of a Medicare Plan once during the time that the beneficiary is enrolled with the Medicare Plan. If a Medicare Plan sends a routine document to an enrollee such as a premium bill, it would be a best effort to ensure that such routine documents are in an acceptable alternate format without the enrollee having to ask each time for the communication to be in the alternate format. When an oversight is identified, the Medicare Plan should provide the document in the accessible format and ensure that the individual is not given less of an opportunity to participate in the Medicare Plan's activities or given less time to make a decision based on the information.

If the enrollee leaves the Medicare Plan and returns, the individual may need to make the request again. Also, a potential enrollee or member of the public may need to make the request each time new communications are requested; this reduces the burden on Medicare Plans to track alternate format requests from individuals who are not enrollees.

15. What evidence is needed to prove a disability in order to receive communications in an alternate format?

RESPONSE: There is no need to prove a disability in order to receive auxiliary aids or communications in an alternate format. Medicare plans should fulfill requests for communications in an accessible format when requested by an enrollee or member of the public.

As discussed in FAQs no. 11, 12 and 19, in the event the Medicare Plan is not able to fulfill a request for communications in an alternate format, the Medicare Plan should make every attempt to provide accessible communications that meet the individual's communications needs. In order to meet the documentation requirements of 45 C.F.R. § 92.202(a) and 28 C.F.R. § 35.164, the Medicare Plan should document the communications offered and how it reached any decisions to deny a request based on the *Burden and Nature of the Benefit* standards, not proof of disability. Medicare Plans should treat the *Burden* and *Nature-of-the-Benefit* standards as very high standards. If CMS and/or HHS' OCR request the Medicare Plan's documentation of its decision to deny a request, they will apply a very high standard when reviewing the decision.

16. Can an enrollee change his or her alternate format preference(s) with a Medicare Plan?

RESPONSE: Yes.

17. Do Medicare Plans have to provide potential enrollees with marketing materials in alternate formats?

RESPONSE: Yes, if the potential enrollee makes such a request to the Medicare Plan. Direct-mail marketing campaign materials, significant publications, and significant communications must comply with 45 C.F.R. § 92.8. *See* FAQ no. 2 *above*.

18. What is the responsibility of a Medicare Plan to provide assistance during a sales event to those with hearing impairments, other than providing an interpreter? These are events that are typically held in a public facility, such as a town hall, restaurant, etc.

RESPONSE: Medicare Plans should include information in marketing materials for sponsored events and programs providing a communication vehicle for individuals with disabilities to make requests for auxiliary aids or services.

19. Are Medicare Plans required to provide large communications or publications in a requested alternate format, such as a provider directory?

RESPONSE: Medicare Plans must take appropriate steps to ensure effective communication with individuals with disabilities. The Medicare Plan may contact the individual and determine whether

there is a more effective way to communicate the large document to the individual, such as calling the individual and working with the individual to access and search the Medicare Plan's information or Web site. If it is determined, giving weight to the individual's request, that the requested format is the only effective way to communicate with the individual, the Medicare Plan will have to communicate with the individual in the requested format, unless doing so would impose undue financial and administrative burdens or would cause a fundamental alteration in the nature of a service, program, or activity. Medicare Plans must treat the *Burden* and *Nature-of-the-Benefit* standards as very high standards. If CMS and/or HHS' OCR request the Medicare Plan's documentation of its decision to deny a request, they will apply a very high standard when reviewing the decision.

20. How do Medicare Plans approach a request for large print identification card? Can Medicare Plans print and laminate a large print version of the identification card for the member?

RESPONSE: Keeping in mind that identification cards have limited space, Medicare Plans should adjudicate requests for identification cards in accessible formats in an appropriate manner to ensure that individuals with disabilities are able to have access to the information they require. For example, a Medicare Plan could work with the individual to explain that identification cards are generally for providers' use and that the Medicare Plan could send a supplemental and accessible communication to the individual explaining the information on the card.

21. Will Medicare Plans have to convert all documents into various alternate formats in anticipation of a request?

RESPONSE: No. Keeping in mind the discussion throughout these FAQs, Medicare Plans need only make documents available in alternate formats upon request. Medicare Plans should remember that, unless one of the standards for denial is met, they must provide marketing communications or enrollment documents in alternate formats, upon request, to a potential enrollee. The Medicare Plan's communications must be received in a timely manner to ensure that the individual has equal access to the Medicare Plan's information. Medicare Plans could consider making certain documents, such as static documents, accessible via their Web site, but if requested, would still need to provide these communications in the requested format.

22. Are CMS model materials available in alternate formats for Medicare Plans to utilize?

RESPONSE: It is the responsibility of the Medicare Plans to produce its materials in accessible formats when requested.

23. What does the phrase "timely manner" mean with respect to providing a communication or publication in an alternate format?

RESPONSE: The phrase "timely manner" means that the disabled individual is provided with communications or publications in the requested format, or another effective format for the individual, within a timeframe that will allow the individual the same opportunity to participate as a non-disabled individual. Enrollees, applicants, and members of the public should not be disadvantaged for requesting communications in alternate formats, and therefore should have the same opportunity to participate in the Medicare Plan's activities, such as enrollment and accessing benefits, as a non-disabled individual. For example, a disabled individual should not have less time to make a decision or act based on a communication or publication than a non-disabled individual.

As part of this equal opportunity to participate, individuals should have the same level of access to information as an individual not requesting information in an alternate format. The term "access" includes providing information in a format that the given individual can understand. For example, if an individual states that s/he cannot understand the text of a Medicare Plan's Web site due to a disability, but the Web site meets accessibility standards, the Medicare Plan has to provide the individual with the information in the alternate format in a timely manner.

Delays in providing materials in alternate formats can impact timeframes that enrollees and potential enrollees may have to take certain actions. If communications are not provided in a timely manner, potential impacts include disadvantaging an individual's opportunity to take full advantage of enrollment periods, the appeals process, the opportunity to pay premiums in a timely manner, etc.

For example, a disabled individual used an out-of-network provider and now requests instructions in an alternate format as to how to request that the Medicare Plan reimburse the beneficiary for the out-of-pocket claim. If the Medicare Plan requires the claim to be filed within a certain amount of time, it must take into account any added time needed to provide the instructions in the alternate format. If it took the Medicare Plan an extra three days to put the instructions into the alternate format, three days should be added to the length of time in which the Medicare Plan will accept the individual's claim.

24. What is the applicable adjudication timeframe for meeting coverage determinations and appeals requirements for Medicare Plans producing materials in an accessible format? Is there an exception process to avoid audit findings?

RESPONSE: Medicare Plans are responsible for having appropriate processes in place so that they can meet the applicable regulatory adjudication and notice timeframes. This includes cases when a Medicare Plan has to produce a notice in an alternate format.

By citing applicable statutes in Appendix 2 of the *Medicare Marketing Guidelines, CMS* reiterates that Medicare Plans must ensure effective communication with individuals with disabilities and provide them with auxiliary aids and services. CMS issued HPMS memos and an HPMS email reminding Medicare Plans of their responsibility to comply with Section 504 and Section 1557, forbidding all Medicare Plans from excluding or denying individuals with disabilities an equal opportunity to receive program benefits and services.

We believe this guidance informs Medicare Plans of their obligation to provide materials in an alternate format if requested by the enrollee. Medicare Plans are responsible for complying with the timely-notice requirements (set forth at 42 CFR Part 422, Subpart M, and 42 CFR Part 423, Subpart M, respectively) in all cases.

If there are certain facts and circumstances when the Plan has difficulty producing an alternate format within the applicable adjudication timeframe, the Plan should document the facts and circumstances, including an explanation of why the documentation could not be produced within the regulatory timeframe, and make best efforts to communicate the information to the individual via the most effective means. The Medicare Plan should document how it ensured that the individual had an equal opportunity to participate in the program or activity.

If the deadline is mandated by law or contract with CMS, the Medicare Plan should contact its CMS Account Manager to discuss the matter.

25. Will Medicare Plans have to survey their membership for the purpose of determining if an enrollee would like to receive communications in an alternate format?

RESPONSE: No. At this time, Medicare Plans are not required to survey their membership for the purpose of determining if an enrollee would like to receive communications in an alternate format. However, as noted in other responses within this document, Medicare Plans must ensure enrollees are aware of the communication options available to them, and respond to requests accordingly.

26. Are Medicare Plans required to provide both the standard and alternate format?

RESPONSE: Ultimately, a Medicare Plan must be able to effectively communicate with individuals with disabilities so that equal access to the Medicare Plan benefits is maintained. A Medicare Plan could consider a process similar to the process CMS utilizes. Except for large print materials, CMS generally provides both the standard and requested alternate format for custom notices and letters. This is because some notices and letters may be used to take another step and CMS wants to accommodate the individual's ability to receive assistance as the individual desires. CMS does not, however, provide publications or static documents in both the standard and requested alternate format.

27. Does a Medicare Plan need to have a grievance process for individuals requesting communications in an alternate format?

RESPONSE: Pursuant to 45 C.F.R. § 92.7, any Medicare Plan with 15 or more employees must have a grievance process in place that incorporates appropriate due process and provides prompt and equitable resolution of grievances. Medicare Plans meeting this criterion must designate at least one employee to coordinate the Medicare Plan's alternate-format responsibilities, including the investigation of complaints related to an individual's request for an alternate format. This employee, or group of employees, may be the same employee or employees responsible for

compliance with 45 C.F.R. Part 92. The Medicare Plan's grievance process does not change the individual's right to file a complaint with CMS and/or HHS' OCR.

Under existing requirements in the MA, Cost Plan, Part D and PACE programs and other applicable law, a Medicare Plan must already have grievance procedures. See for example, 42 CFR §§ 417.436(a) (7), 417.600(b) (1), 422.564, 423.564, and 460.120. A Medicare Plan may combine the grievance procedure required under Section 1557 with procedures they use to address other grievances, including those unrelated to individuals' civil rights.

28. How will CMS enforce compliance?

RESPONSE: Medicare Plans are reminded of their responsibility to comply with Section 504 of the Rehabilitation Act of 1973. CMS added a Section 504 complaint subcategory to the Complaint Tracking Module (CTM) to capture complaints from beneficiaries relating to their difficulties acquiring materials in alternate formats. The Section 504 subcategory is called "Difficulties Acquiring Materials in Alternate Formats," and is located under the Customer Service category. As Medicare Plans are held accountable for the prompt resolution of complaints in the CTM, CMS will monitor this category.

Section 504 compliance may also be added to key Medicare Plan management documents and processes for oversight.