

**DEPARTMENT OF MANAGED HEALTH CARE  
OFFICE OF PLAN MONITORING  
DIVISION OF PLAN SURVEYS**

**TECHNICAL ASSISTANCE GUIDE**

**LANGUAGE ASSISTANCE  
ROUTINE MEDICAL SURVEY  
OF  
PLAN NAME**

**DATE OF SURVEY:**

**PLAN COPY**

*Issuance of this June 1, 2020 Technical Assistance Guide renders all other versions obsolete.*

# LANGUAGE ASSISTANCE TAG

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## Requirement LA-001: Language Assistance Policies and Procedures

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Director of Quality Management Program and/or the executive with overall responsibility for the Plan's Language Assistance Program (LAP)
- Director of Operations
- Manager of Member/Customer Services
- Director of Provider Networks or contracting

### DOCUMENTS TO BE REVIEWED

- The Plan's LAP and/or language assistance (LA) policies and procedures, including those relating to:
  - LA services (including translation and interpretation)
  - LA staff training
  - LAP compliance monitoring
  - Informing enrollees of the availability of LA services
- The job description of the individual(s) or committee(s) with overall responsibility for the LAP
- For health plans with both Medi-Cal and non-Medi-Cal lines of business, the Department's determination(s) regarding the compliance of the Plan's LAP as documented in the e-Filing system, if any

### **LA-001 - Key Element 1:**

1. The Plan has written policies and procedures describing the LAP. 28 CCR 1300.67.04(a), (c).

Assessment Questions
1.1 Does the Plan only provide services under Medi-Cal and/or Medicare contracts to enrollees of one or both of those programs? <b>If yes</b> , stop. The Plan is exempt from the LAP regulations this TAG assesses compliance with per Rule 1300.67.04(a)(1). <b>If no</b> , continue.

1.2 Does the Plan have both Medi-Cal and non-Medi-Cal lines of business, has it requested (as part of its LAP filing) and received the Department's determination of compliance based on compliance with the Medi-Cal LA services standards, and does it apply its Medi-Cal LAP standards to all enrollees in its non-Medi-Cal lines of business?

**If yes**, stop. The Plan is deemed compliant with the LAP regulations this TAG assesses compliance with per Rule 1300.67.04(a)(2)-(3).

1.3 Does the Plan have written policies and procedures describing the LAP?

### **End of Requirement LA-001: Language Assistance Policies and Procedures**

## Requirement LA-002: Enrollee Assessment

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Director of Quality Management or executive with overall responsibility for the Plan's LAP

### DOCUMENTS TO BE REVIEWED

- Policies and procedures relating to the enrollee assessment and survey processes
- Data sources for completing the demographic profile
- The Plan's demographic profile and language needs assessment (report or other documentation)
- Evidence of statistical analysis of the demographic data
- Enrollee linguistic needs survey
- Disclosure or notice to enrollees regarding the availability of LA services
- The processes for allowing disclosure of the demographic profile to the DMHC upon request for regulatory purpose and to contracting providers upon request for lawful purposes

### **LA-002 - Key Element 1:**

1. **The Plan has standards for enrollee assessment and has developed a demographic profile.**  
**CA Health and Safety Code section 1367.04(b)(1); 28 CCR 1300.67.04(c)(1), (e)(1).**

<b>Assessment Questions</b>	
	The Plan has standards and a policy for completing an enrollee language needs assessment and demographic profile.
1.1	Did the Plan develop a demographic profile of the enrollee population?
1.2	Does the Plan demonstrate that statistically valid methods for population analysis were applied in developing the demographic profile?
1.3	Has the Plan updated the demographic profile during the survey review period if three years elapsed since the last update?
1.4	Has the Plan completed an update of its assessment of enrollee language needs during the survey review period if three years elapsed since the last update?

**LA-002 - Key Element 2:**

**2. The Plan demonstrates that it has surveyed the linguistic needs of the Plan's enrollees.**

**CA Health and Safety Code section 1367.04(b); 28 CCR 1300.67.04(c)(1)(B).**

<b>Assessment Questions</b>	
2.1	Has the Plan surveyed enrollees in a manner designed to identify the linguistic needs of each of the Plan's enrollees?
2.2	Does the Plan record the information provided by a responding enrollee in the enrollee's file?
2.3	If the Plan uses a disclosure to comply with the survey requirement, does the disclosure/notice comply with all of the following: <ul style="list-style-type: none"><li>• Is the notice in English and the Plan's threshold languages;</li><li>• Distributed to all subscribers;</li><li>• Explain the availability of free language assistance services; and</li><li>• Includes how to inform the plan and relevant providers regarding preferred written and spoken languages?</li></ul>

**LA-002 - Key Element 3:**

**3. The Plan has identified its threshold language(s).**

**CA Health and Safety Code section 1367.04(b)(1)(A); 28 CCR 1300.67.04(b)(5).**

<b>Assessment Questions</b>	
3.1	Has the Plan identified its threshold language(s) based on the statutory formula in section 1367.04(b)(1)(A)?

**End of Requirement LA-002: Enrollee Assessment**

## **Requirement LA-003: Language Assistance Services and Nondiscrimination**

### **INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED**

#### **Staff responsible for the activities described above, for example:**

- Director of QM Program and/or executive with overall responsibility for the Plan's LAP
- Manager and staff of Member/Customer Services
- Director or Manager of Provider Networks or Provider Contracting, Delegated Programs
- Cultural and Linguistic Coordinator/ LAP Coordinator

### **DOCUMENTS TO BE REVIEWED**

- Plan's LAP and LA policies & procedures
- Workflow / process map / algorithm for accessing interpreter services by point of contact
- If applicable, samples of translated documents such as applications, consent forms, standard and non-standard letters
- Any and all evidence/documentation of internal interpretation/translation proficiency assessments, which may include, but is not limited to, staff proficiency attestation forms and samples of completed attestations, staff proficiency assessment tools and assessment results, etc.
- If the Plan has contracted with a vendor to provide LA services, any and all evidence/documentation of the vendor's interpretation/translation proficiency, which may include, but is not limited to, assessment tools, vendor proficiency requirements for LA services, vendor language certifications, etc.
- Log(s) or report(s) of LA services provided by the Plan (directly or through vendor contracts)
- Log(s) or report(s) of LA services accessed through a provider's office.
- Sample of contracts/ contract amendments/ or provider manuals (if incorporated by reference in the provider contracts) between the Plan and providers incorporating language regarding LAP requirements
- Plan's website (identifying all areas related to LA services, including but not limited to: notice of availability, translated vital documents, grievance forms and information, etc.)
- IF THE PLAN DELEGATES LAP: Pre-delegation assessments, policies and procedures, delegation agreement, roles, responsibilities and Plan oversight:
  - Delegation audit tools, related documents;
  - Delegated LAP policies and procedures, if applicable;
  - Results of periodic audit of delegated activities, action plans;
  - The Plan's monitoring and collection of any and all evidence/documentation of LA provider(s) proficiency under the delegated LAP(s).

- FOR SPECIALIZED PLANS (utilizing the alternative means of compliance addressed in KE 7 below):
  - Provider directory;
  - Provider quarterly language capability updates regarding any changes.

**LA-003 - Key Element 1:**

1. The Plan has established and implemented LA policies and procedures that address standards for providing LA services.  
28 CCR 1300.67.04(c)(2).

<b>Assessment Questions</b>	
1.1	Has the Plan implemented processes for facilitating access to language services at no cost to the enrollee?
1.2	Has the Plan defined all points of contact where the need for language assistance may be reasonably anticipated?
1.3	Has the Plan defined how <b>translation</b> services are provided to enrollees? (Including how to request services, access services, etc.)
1.4	Does the Plan have processes to provide <b>interpretation</b> services to enrollees at all points of contact? (Including how to request services, access services, etc.)

**LA-003 - Key Element 2:**

2. The Plan demonstrates that it has processes and standards for informing enrollees of the timely availability of free LA services.  
CA Health and Safety Code section 1367.04(b)(1)(B)(v); CA Health and Safety Code section 1367.042(a) and (b); 28 CCR 1300.67.04(c)(2)(C).

<b>Assessment Questions</b>	
2.1	Does the Plan have processes to inform enrollees of the availability of free LA services at all identified points of contact (medical and administrative)?
2.2	Do the processes address both Plan and provider (such as physicians, ancillary providers, pharmacies, facilities, etc.) points of contact?
2.3	Does the Plan demonstrate that it includes the required notice with all <b>vital documents, enrollment materials, and correspondence confirming new or renewed enrollment</b> , except when documents are sent in enrollee's preferred language?



<p>2.4 Do the Plan’s brochures, newsletters, outreach and marketing materials, and other materials routinely disseminated to enrollees include statements – in English and in threshold languages, if applicable – regarding the availability of free LA services?</p>
<p>2.5 In addition to the required notices in threshold languages, does the Plan notify enrollees and the public of the availability in a timely manner of free LA services in the top 15 languages spoken by LEP individuals in California as determined by the State Department of Health Care Services (DHCS) by providing the information:</p> <ul style="list-style-type: none"><li>a) upon initial enrollment and annually upon renewal</li><li>b) in a conspicuously visible location in the EOC</li><li>c) at least annually in or with newsletters, outreach, or other routinely disseminated materials</li><li>d) on the Plan’s website in a manner that allows enrollees and members of the public to easily locate the information? NOTE – Certain specialized plans may request and receive an exemption from this requirement pursuant to Section 1367.042(c). Any such granted exemptions must be published on the Department website. This question is inapplicable to plans that have received such exemptions.</li></ul>
<p>2.6 Does the Plan notify enrollees and the public of the availability in a timely manner of free appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, when the aids and services are necessary to ensure equal opportunity to participate for individuals with disabilities by providing the information:</p> <ul style="list-style-type: none"><li>a) upon initial enrollment and annually upon renewal</li><li>b) in a conspicuously visible location in the EOC</li><li>c) at least annually in or with newsletters, outreach, or other routinely disseminated materials</li><li>d) on the Plan’s website in a manner that allows enrollees and members of the public to easily locate the information? NOTE – Certain specialized plans may request and receive an exemption from this requirement pursuant to Section 1367.042(c). Any such granted exemptions must be published on the Department website. This question is inapplicable to plans that have received such exemptions.</li></ul>

**LA-003 - Key Element 3:**

**3. The Plan provides required notices re nondiscrimination, grievance procedures, and how to file a discrimination complaint.  
CA Health and Safety Code section 1367.042(a)(3)-(5).**

<b>Assessment Questions</b>	
3.1	Does the Plan notify enrollees and the public that it does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability by providing the information: a) upon initial enrollment and annually upon renewal b) in a conspicuously visible location in the EOC c) at least annually in or with newsletters, outreach, or other routinely disseminated materials d) on the Plan's website in a manner that allows enrollees and members of the public to easily locate the information?
3.2	Does the Plan notify enrollees and the public of the availability of the Plan's grievance procedure, how to file a grievance (including the name of the plan representative and the telephone number, address, and email address of the Plan representative who may be contacted about the grievance), and how to submit the grievance to the Department for review after completing the grievance process or participating in the process for at least 30 days: a) upon initial enrollment and annually upon renewal b) in a conspicuously visible location in the EOC c) at least annually in or with newsletters, outreach, or other routinely disseminated materials d) on the Plan's website in a manner that allows enrollees and members of the public to easily locate the information?
3.3	Does the Plan notify enrollees and the public of how to file a discrimination complaint with the United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex by providing the information: a) upon initial enrollment and annually upon renewal b) in a conspicuously visible location in the EOC c) at least annually in or with newsletters, outreach, or other routinely disseminated materials d) on the Plan's website in a manner that allows enrollees and members of the public to easily locate the information?

**LA-003 - Key Element 4:**

- 4. IF APPLICABLE: .The Plan demonstrates that it has processes and standards in place for providing translation services.  
CA Health and Safety Code section 1363(b)(1); CA Health and Safety Code section 1367.04(b)(1)(C); 28 CCR 1300.67.04(c)(2)(F).**

<b>Assessment Questions</b>	
4.1	Does the Plan describe how it provides or arranges for translation of vital documents at no charge to enrollees?
4.2	Does the Plan include – with non-standardized enrollee-specific vital documents – a written notice of the availability of free interpretation services?
4.3	In addition to the notice referenced in 4.2 above, does the Plan include – with non-standardized enrollee- specific vital documents – a written notice of the availability of interpretation services in the top 15 languages spoken by LEP individuals in California as determined by DHCS?
4.4	Does the Plan’s LAP require – upon the enrollee’s request – a written translation of a non-standardized enrollee-specific vital document into a threshold language within 21 days? For grievances that require expedited review, the Plan may satisfy this requirement by providing notice of the availability and access to oral interpretation service.
4.5	Does the Plan ensure that the translation is accurate?
4.6	Does the Plan ensure that non-English translations of vital documents meet the same standards as the English versions?

**LA 003 – Key Element 5:**

- 5. IF APPLICABLE: The Plan has translated vital documents into threshold languages as required.  
CA Health and Safety Code sections 1367.04(b)(1)(B) and (C); 28 CCR 1300.67.04(c)(2)(F)(ii), (v).**

<b>Assessment Questions</b>	
5.1	<p>Has the Plan specified the standardized and enrollee-specific vital documents that must be translated?</p> <p>Vital documents shall include all of the following:</p> <ul style="list-style-type: none"> <li>• Applications</li> <li>• Consent forms</li> <li>• Letters containing important information regarding eligibility and participation criteria</li> <li>• Notices pertaining to the denial, reduction, modification or termination of services and benefits, and the right to file a grievance or appeal</li> <li>• Notices advising LEP persons of the availability of free LA services and other outreach materials that are provided to enrollees</li> <li>• Claims processing documents that require a response from the enrollee</li> <li>• Disclosure forms or excerpts or a standardized health plan benefits and coverage matrix</li> </ul>
5.2	Does the Plan's list of standardized and enrollee-specific vital documents that must be translated meet statutory requirements?
5.3	Has the Plan translated the specified standardized vital documents into threshold languages?
5.4	Does the Plan provide a written translation of a non-standardized enrollee-specific vital document into a threshold language within 21 days of the request?

**LA-003 - Key Element 6:**

6. **The Plan demonstrates that it has processes and standards for ensuring the proficiency of individuals providing translation and interpretation services. CA Health and Safety Code section 1367.04(b)(1)(C)(4); 28 CCR 1300.67.04(c)(2)(H).**

<b>Assessment Questions</b>	
6.1	Does the Plan define processes and standards for ensuring the proficiency of those providing translation and interpretation services, including <b><i>internal Plan staff and contract or vendor staff</i></b> ?
6.2	Do the Plan's language proficiency standards include: <ul style="list-style-type: none"> <li>a) A documented and demonstrated proficiency in both English and the other language and</li> </ul>

	b) A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems?
6.3	Do the Plan’s language proficiency standards include education and training in interpreting ethics, conduct, and confidentiality? (Or has the Plan adopted and does it apply, in full, the ethics, conduct, and confidentiality standards promulgated by the California Healthcare Interpreters Association or the National Council on Interpreting in Health Care?)
6.4	Does the Plan ‘test’ or ‘validate the quality’ of services provided by those providing translation and interpretation services (documented and demonstrated proficiency in English and other language, fundamental knowledge in both languages of health care terminology and delivery system, and education and training in ethics, conduct, and confidentiality)?

**LA-003 - Key Element 7:**

**7. The Plan demonstrates that it has processes and standards for providing interpretation services.**

**CA Health and Safety Code section 1317.1; CA Health and Safety Code section 1367.04(b)(4); 28 CCR 1300.67.04(c)(2)(G), (d)(9).**

<b>Assessment Questions</b>	
7.1	Does the Plan provide or arrange for interpretation services at no cost to the enrollee at all points of contact, including <b>medical/clinical and non-medical/administrative</b> points of contact? (Such as physician’s office, ancillary services, pharmacies, facilities, hospitals, nurse advice lines, administrative offices, claims support contacts, etc.) <b>NOTE:</b> Certain specialized plans will be in compliance with this requirement if the answer to question 7.7 below is “yes.”
7.2	Does the Plan specify quality assurance standards for timely delivery of interpretation services for <b>routine, urgent, and emergency</b> health care services?
7.3	Does the Plan arrange or coordinate timely interpretation services for medical points of contact as well as administrative points of contact?
7.4	Is the range of interpretation services appropriate for the particular point of contact?

7.5	<p>Does the Plan ensure that qualified interpretation services are offered to LEP enrollees, even when an enrollee is accompanied by a family member or friend that can provide interpretation services?</p> <p><b>NOTE:</b> Certain specialized plans will be in compliance with this requirement if the answer to question 7.7 below is “yes.”</p>
7.6	<p>If the offer is refused, is the information documented in the Plan file?</p> <p><b>NOTE:</b> Certain specialized plans will be in compliance with this requirement if the answer to question 7.7 below is “yes.”</p>
7.7	<p><b>SPECIALIZED PLANS ONLY</b> (Except non-EAP behavioral health plans) These plans may comply with the requirements of questions 7.1, 7.5, and 7.6 above if they do all of the following:</p> <ul style="list-style-type: none"> <li>• Identify in provider directories contracting providers who are bilingual or employ bilingual office staff, based on language capability disclosure forms signed by the bilingual individuals attesting to their fluency in languages other than English;</li> <li>• Require all contracting providers to provide quarterly updates of any changes in language capabilities of current providers/staff by submitting new language capability disclosure forms, and the Plan updates its provider directories accordingly; and</li> <li>• The Plan’s QA audits of contracting providers confirm and document the accuracy of provider language capability disclosure forms and attestations.</li> </ul>
7.8	<p>The Plan does not require LEP enrollees to provide their own interpreters or rely on a staff member who does not meet qualifications?</p>
7.9	<p>The Plan does not require LEP enrollees to rely on an accompanying adult or minor child to facilitate communication unless:</p> <ol style="list-style-type: none"> <li>a) during an emergency, as described in Section 1317.1, a qualified interpreter is not immediately available or</li> <li>b) the LEP enrollee specifically requests that an accompanying adult interpret or facilitate communication, the adult agrees to provide that assistance, and reliance on the adult for that assistance is appropriate under the circumstances?</li> </ol>
7.10	<p>Has the Plan defined a list of the non-English languages likely to be encountered among the Plan’s enrollees?</p>
7.11	<p>Does the Plan provide evidence that interpretation services are available in languages other than threshold languages?</p>

**LA-003 - Key Element 8:**

8. The Plan's grievance system addresses the cultural and linguistic needs of its enrollee population.  
CA Health and Safety Code section 1367.04(b)(1)(B)(iv); 28 CCR 1300.68(b)(3) and (7); 28 CCR 1300.67.04(c)(2)(D).

<b>Assessment Questions</b>	
8.1	Does the Plan ensure that LEP enrollees receive information regarding their rights to <b>file a grievance and request an IMR</b> in threshold languages and through oral interpretation?
8.2	Has the Plan translated and distributed grievance and IMR forms and procedures in threshold languages?
8.3	Does the Plan ensure that these translated forms and procedures are readily available to <b>enrollees, contracting providers, contracting facilities, and on the Plan's website?</b>
8.4	Does the Plan offer interpretation services for LEP enrollees who file a grievance or seek an IMR?

**End of Requirement LA-003: Language Assistance Services**

## Requirement LA-004: Staff Training

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Cultural and Linguistic Coordinator/ LAP Coordinator
- Director of Human Resources
- Manager of Training
- Member / Customer Service staff

### DOCUMENTS TO BE REVIEWED

- LAP staff training curriculum
- LAP training materials
- LAP training schedule
- LAP training evaluation summaries
- Resumes of LAP trainers

### **LA-004 - Key Element 1:**

1. The Plan has established and implemented an LA training program for all staff who have routine contact with LEP enrollees.  
28 CCR 1300.67.04(c)(3).

<b>Assessment Questions</b>	
1.1	Does the LA training program apply to all Plan staff that have routine contact with LEP enrollees?
1.2	Is the Plan's training program comprehensive, including all required elements? (Working effectively with LEP enrollees, working with interpreters, cultural diversity, LAP elements.)
1.3	Has the Plan made reasonable efforts to educate contracted medical providers, ancillary providers, and pharmacies about making interpretation services available for enrollees?

### **End of Requirement LA-004: Staff Training**



## Requirement LA-005: Contracted Providers and the Language Assistance Program

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Director of Provider Relations
- Medical Director
- Manager, Provider Contracting

### DOCUMENTS TO BE REVIEWED

- Policies and procedures that describe provider LAP standards
- Standards and/or criteria for determining bilingual provider and office staff proficiency
- Provider contracts, including contract templates or amendments to provider contracts that reference compliance with the Plan's LAP
- Provider manuals
- Sample provider newsletters
- Provider section of the Plan's website
- Provider directory

#### **LA-005 - Key Element 1:**

1. The Plan has amended provider contracts to require providers to comply with the LAP requirements and agreement to provide information necessary to assess compliance.

CA Health and Safety Code section 1367.04(f); 28 CCR 1300.67.04(e)(4)(A).

Assessment Questions	
1.1	Do Plan contracts with providers require the provider to comply with the Plan's LAP?
1.2	Do the Plan's contracts with providers require providers to provide any information necessary to assess compliance?

#### **LA-005 - Key Element 2:**

2. The Plan shall inform all contracted providers of its LAP.  
28 CCR 1300.67.04(c)(1)(C), (2)(E).

Assessment Questions	
2.1	Does the Plan disclose enrollee demographic profile data, the Plan's threshold languages, and language preference data gathered to contracting providers (including doctors' offices,

	hospitals, labs, radiology centers, physical therapy offices, and pharmacy services) upon request?
2.2	Has the Plan established and implemented policies and procedures that ensure <b>contracted providers</b> (such as doctors' offices, hospitals, labs, radiology centers, physical therapy offices, and pharmacy services) <b>are informed</b> of the Plan's standards and methods for providing LA services at no charge to enrollees?

**LA-005 - Key Element 3:**

- 3. The Plan has established and implemented on-going oversight and monitoring of LA services delegated to contracted providers, hospitals, and/or facilities.**  
**28 CCR 1300.67.04(c)(2)(G)(iv), (4)(A) and (e)(4); 28 CCR 1300.70(a)(1), (b)(2)(G), (c).**

<b>Assessment Questions</b>	
3.1	Does the Plan delegate the provision of any LA services (or incorporate a contracting hospital or provider group's LAP)? <b><i>If 'No,' stop here; if 'Yes,' continue.</i></b>
3.2	Do minutes of appropriate committee meetings indicate regular Plan review of LA delegate reports and activities?
<b>3.3 Comments</b>	
3.4	Does the Plan implement corrective action and conduct follow-up reviews to address any deficiencies?

**End of Requirement LA-005: Contracts with Providers**

## Requirement LA-006: Compliance Monitoring

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- LAP Coordinator/Compliance Officer or equivalent
  - QA Director or equivalent
  - Grievances and Appeals Coordinator/ Customer Service Director
  - Provider Relations staff
  - Staff responsible for developing and analyzing reports of the LAP
  - Accounting Manager (usage reports)
- **DOCUMENTS TO BE REVIEWED**
- Exhibit J e-filing/ amendment to QA program related to LAP and any updates
  - QA work plans related to LAP or services
  - Monitoring and evaluation reports noted in the LAP QA work plan activities, e.g., LAP grievances, PQI, provider complaints, language line usage reports.
  - Plan's evaluation of LAP

### **LA-006 - Key Element 1:**

1. **The Plan has defined policies and has implemented an active and ongoing program to continuously monitor the compliance of its LAP.  
28 CCR 1300.67.04(c); 28 CCR 1300.70(b)(2)(B), (F), and (G).**

<b>Assessment Questions</b>	
1.1	Does the Plan have policies and procedures that define how the Plan monitors its LAP?
1.2	Does the Plan have a designated person and/or department responsible for LAP monitoring?
1.3	Does the Plan's monitoring program include internal (and external, if appropriate) monitoring?
1.4	Does the Plan monitor, evaluate, and take action as appropriate, measuring the four LAP components: enrollee assessment, provision of language assistance services, staff training, and compliance?
1.5	Does the Plan have a mechanism to ensure that contracted providers comply with LA requirements?
1.6	Are reports from LAP compliance monitoring submitted and reviewed through the Plan's QA reporting channels (and/or committee structure)?
1.7	Does the Plan re-measure its performance to determine if corrective actions have resulted in improved performance or the ability to meet compliance goals?

## **End of Requirement LA-006: Compliance Monitoring**

## Statutory/Regulatory Citations

### CA Health and Safety Code section 1317.1

Unless the context otherwise requires, the following definitions shall control the construction of this article and Section 1371.4:

(a)(1) "Emergency services and care" means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

(2)(A) "Emergency services and care" also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

(B) The care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a general acute care hospital, as defined in subdivision (a) of Section 1250, or to an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, pursuant to subdivision (k). Nothing in this subparagraph shall be construed to permit a transfer that is in conflict with the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code).

(C) For the purposes of Section 1371.4, emergency services and care as defined in subparagraph (A) shall not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590) of Part 3 of Division 9 of the Welfare and Institutions Code, to the extent that those services are excluded from coverage under those contracts.

...

(b) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient's health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(c) "Active labor" means a labor at a time at which either of the following would occur:

(1) There is inadequate time to effect safe transfer to another hospital prior to delivery.

(2) A transfer may pose a threat to the health and safety of the patient or the unborn child.

...

(k)(1) “Psychiatric emergency medical condition” means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- (A) An immediate danger to himself or herself or to others.
- (B) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

**CA Health and Safety Code 1363(b)(1) LA-003 KE4**

(b)(1) As of July 1, 1999, the director shall require each plan offering a contract to an individual or small group to provide with the disclosure form for individual and small group plan contracts a uniform health plan benefits and coverage matrix containing the plan's major provisions in order to facilitate comparisons between plan contracts. The uniform matrix shall include the following category descriptions together with the corresponding copayments and limitations in the following sequence:

- (A) Deductibles.
- (B) Lifetime maximums.
- (C) Professional services.
- (D) Outpatient services.
- (E) Hospitalization services.
- (F) Emergency health coverage.
- (G) Ambulance services.
- (H) Prescription drug coverage.
- (I) Durable medical equipment.
- (J) Mental health services.
- (K) Chemical dependency services.
- (L) Home health services.
- (M) Other.

**CA Health and Safety Code 1367.042**

(a) A health care service plan shall notify enrollees and members of the public of all of the following information:

(1) The availability of language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner pursuant to Section 1367.04, and how to access these services. This information shall be available in the top 15 languages spoken by limited-English-proficient individuals in California as determined by the State Department of Health Care Services.

(2) The availability of 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 those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

(3) The health plan does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

(4) The availability of the grievance procedure described in Section 1368, how to file a grievance, including the name of the plan representative and the telephone number, address, and email address of the plan representative who may be contacted about the grievance, and how to submit the grievance to the department for review after completing the grievance process or participating in the process for at least 30 days. (5)

How to file a discrimination complaint with the United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

(b) The information required to be provided pursuant to this section shall be provided to an enrollee with individual coverage upon initial enrollment and annually thereafter upon renewal, and to enrollees and subscribers with group coverage upon initial enrollment and annually thereafter upon renewal. A health care service plan may include this information with other materials sent to the enrollee. The information shall also be provided in the following manner:

(1) In a conspicuously visible location in the evidence of coverage.

(2) At least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the plan's enrollees.

(3) On the Internet Web site published and maintained by the health care service plan, in a manner that allows enrollees, prospective enrollees, and members of the public to easily locate the information.

(c)(i) A specialized health care plan that is not a covered entity, as defined in Section 92.4 of Title 45 of the Code of Federal Regulations, subject to Section 1557 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18116) may request an exemption from the requirements under this section.

(ii) The department shall not grant an exemption under this subdivision to a specialized health care service plan that arranges for mental health benefits, except for employee assistance program plans.

(iii) The department shall provide information on its Internet Web site about any exemptions granted under this subdivision (d) This section shall not apply to Medi-Cal

managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

#### **CA Health and Safety Code section 1367.04**

(a) Not later than January 1, 2006, the department shall develop and adopt regulations establishing standards and requirements to provide health care service plan enrollees with appropriate access to language assistance in obtaining health care services.

(b) In developing the regulations, the department shall require every health care service plan and specialized health care service plan to assess the linguistic needs of the enrollee population, excluding Medi-Cal enrollees, and to provide for translation and interpretation for medical services, as indicated. A health care service plan that participates in the Healthy Families Program may assess the Healthy Families Program enrollee population separately from the remainder of its enrollee population for purposes of subparagraph (A) of paragraph (1). A health care service plan that chooses to separate its Healthy Families Program enrollment from the remainder of its enrollee population shall treat the Healthy Families Program population separately for purposes of determining whether subparagraph (A) of paragraph (1) is applicable, and shall also treat the Healthy Families Program population separately for purposes of applying the percentage and numerical thresholds in subparagraph (A) of paragraph. The regulations shall include the following:

(1) Requirements for the translation of vital documents that include the following:

LANGUAGE ASSISTANCE

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- (A) A requirement that all vital documents, as defined pursuant to subparagraph (B), be translated into an indicated language, as follows:
- (i) A health care service plan with an enrollment of 1,000,000 or more shall translate vital documents into the top two languages other than English as determined by the needs assessment as required by this subdivision and any additional languages when 0.75 percent or 15,000 of the enrollee population, whichever number is less, excluding Medi-Cal enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language.
  - (ii) A health care service plan with an enrollment of 300,000 or more but less than 1,000,000 shall translate vital documents into the top one language other than English as determined by the needs assessment as required by this subdivision and any additional languages when 1 percent or 6,000 of the enrollee population, whichever number is less, excluding Medi-Cal enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language.
  - (iii) A health care service plan with an enrollment of less than 300,000 shall translate vital documents into a language other than English when 3,000 or more or 5 percent of the enrollee population, whichever number is less, excluding Medi-Cal enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language.
- (B) Specification of vital documents produced by the plan that are required to be translated. The specification of vital documents shall not exceed that of the United States Department of Health and Human Services (HHS) Office for Civil Rights (OCR) Policy Guidance (65 Federal Register 52762 (August 30, 2000)), but shall include all of the following:
- (i) Applications.
  - (ii) Consent forms.
  - (iii) Letters containing important information regarding eligibility and participation criteria.
  - (iv) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal.
  - (v) Notices advising limited-English-proficient persons of the availability of free language assistance and other outreach materials that are provided to enrollees.
  - (vi) Translated documents shall not include a health care service plan's explanation of benefits or similar claim processing information that is sent to enrollees, unless the document requires a response by the enrollee.
- (C)(i) For those documents described in subparagraph (B) that are not standardized but contain enrollee specific information, health care service plans shall not be required to translate the documents into the threshold languages identified by the needs assessment as required by this subdivision, but rather shall include with the documents a written notice of the availability of interpretation services in the threshold languages identified by the needs assessment as required by this subdivision. A health care service plan subject to the requirements in Section 1367.042 shall also include with the documents a written notice of the availability of interpretation services in the top 15 languages spoken by limited-English-proficient (LEP) individuals in



California as determined by the State Department of Health Care Services.

(ii) Upon request, the enrollee shall receive a written translation of the documents described in clause (i). The health care service plan shall have up to, but not to exceed, 21 days to comply with the enrollee's request for a written translation. If an enrollee requests a translated document, all timeframes and deadline requirements related to the document that apply to the health care service plan and enrollees under the provisions of this chapter and under any regulations adopted pursuant to this chapter shall begin to run upon the health care service plan's issuance of the translated document.

(iii) For grievances that require expedited plan review and response in accordance with subdivision (b) of Section 1368.01, the health care service plan may satisfy this requirement by providing notice of the availability and access to oral interpretation services.

(D) A requirement that health care service plans advise limited-English-proficient enrollees of the availability of interpreter services.

(2) Standards to ensure the quality and accuracy of the written translations and that a translated document meets the same standards required for the English language version of the document. The English language documents shall determine the rights and obligations of the parties, and the translated documents shall be admissible in evidence only if there is a dispute regarding a substantial difference in the material terms and conditions of the English language document and the translated document.

(3) Requirements for surveying the language preferences and needs assessments of health care service plan enrollees within one year of the effective date of the regulations that permit health care service plans to utilize various survey methods, including, but not limited to, the use of existing enrollment and renewal processes, subscriber newsletters, or other mailings. Health care service plans shall update the needs assessment, demographic profile, and language translation requirements every three years.

(4) Requirements for individual enrollee access to interpretation services that include the following:

(A) A requirement that an interpreter meets, at a minimum, all of the following qualifications:

(i) Demonstrated proficiency in both English and the target language.

(ii) Knowledge in both English and the target language of health care terminology and concepts relevant to health care delivery systems.

(iii) Adheres to generally accepted interpreter ethics principles, including client confidentiality.

(B) A requirement that the enrollee with limited English proficiency shall not be required to provide his or her own interpreter or rely on a staff member who does not meet the qualifications described in subparagraph (A) to communicate directly with the limited-English-proficient enrollee.

(C) A requirement that the enrollee with limited English proficiency shall not be required to rely on an adult or minor child accompanying the enrollee to interpret or facilitate communication except under either of the following circumstances:

(i) In an emergency, as described in Section 1317.1, if a qualified interpreter is not immediately available for the enrollee with limited English proficiency.

(ii) If the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.

(5) Standards to ensure the quality and timeliness of oral interpretation services provided by health care service plans.

(c) In developing the regulations, standards, and requirements, the department shall consider the following:

(1) Publications and standards issued by federal agencies, such as the Culturally and Linguistically Appropriate Services (CLAS) in Health Care issued by the United States Department of Health and Human Services Office of Minority Health in December 2000, and the United States Department of Health and Human Services (HHS) Office for Civil Rights (OCR) Policy Guidance (65 Federal Register 52762 (August 30, 2000)).

(2) Other cultural and linguistic requirements under state programs, such as Medi-Cal Managed Care Policy Letters, cultural and linguistic requirements imposed by the State Department of Health Care Services on health care service plans that contract to provide Medi-Cal managed care services, and cultural and linguistic requirements imposed by the Managed Risk Medical Insurance Board on health care service plans that contract to provide services in the Healthy Families Program.

(3) Standards adopted by other states pertaining to language assistance requirements for health care service plans.

(4) Standards established by California or nationally recognized accrediting, certifying, or licensing organizations and medical and health care interpreter professional associations regarding interpretation services.

(5) Publications, guidelines, reports, and recommendations issued by state agencies or advisory committees, such as the report card to the public on the comparative performance of plans and reports on cultural and linguistic services issued by the Office of Patient Advocate and the report to the Legislature from the Task Force on Culturally and Linguistically Competent Physicians and Dentists established by former Section 852 of the Business and Professions Code.

(6) Examples of best practices relating to language assistance services by health care providers and health care service plans, including existing practices.

(7) Information gathered from complaints to the HMO Helpline and consumer assistance centers regarding language assistance services.

(8) The cost of compliance and the availability of translation and interpretation services and professionals.

(9) Flexibility to accommodate variations in plan networks and method of service delivery. The department shall allow for health care service plan flexibility in determining compliance with the standards for oral and written interpretation services.

(d) The department shall work to ensure that the biennial reports required by this section, and the data collected for those reports, are consistent with reports required by government-sponsored programs and do not require duplicative or conflicting data collection or reporting.

(e) The department shall seek public input from a wide range of interested parties through advisory bodies established by the director.

(f) A contract between a health care service plan and a health care provider shall

require compliance with the standards developed under this section. In furtherance of this section, the contract shall require providers to cooperate with the plan by providing any information necessary to assess compliance.

(g) The department shall report biennially to the Legislature and advisory bodies established by the director regarding plan compliance with the standards, including results of compliance audits made in conjunction with other audits and reviews. The reported information shall also be included in the publication required under subparagraph (B) of paragraph (1) of subdivision (b) of Section 136000. The department shall also utilize the reported information to make recommendations for changes that further enhance standards pursuant to this section. The department may also delay or otherwise phase-in implementation of standards and requirements in recognition of costs and availability of translation and interpretation services and professionals.

(h)(1) Except for contracts with the State Department of Health Care Services Medi-Cal program, the standards developed under this section shall be considered the minimum required for compliance.

(2) The regulations shall provide that a health plan is in compliance if the plan is required to meet the same or similar standards by the Medi-Cal program, either by contract or state law, if the standards provide as much access to cultural and linguistic services as the standards established by this section for an equal or higher number of enrollees and therefore meet or exceed the standards of the regulations established pursuant to this section, and the department determines that the health care service plan is in compliance with the standards required by the Medi-Cal program. To meet this requirement, the department shall not be required to perform individual audits. The department shall, to the extent feasible, rely on audits, reports, or other oversight and enforcement methods used by the State Department of Health Care Services.

(3) The determination pursuant to paragraph (2) shall only apply to the enrollees covered by the Medi-Cal program standards. A health care service plan subject to paragraph (2) shall comply with the standards established by this section with regard to enrollees not covered by the Medi-Cal program.

(i) This section does not prohibit a government purchaser from including in their contracts additional translation or interpretation requirements, to meet linguistic or cultural needs, beyond those set forth pursuant to this section.

#### **28 CCR 1300.67.04**

(a) Application.

(1) Every health care service plan, including specialized health care service plans (plans), shall comply with the requirements of this section. The requirements of this section shall not apply to plan contracts for the provision of services to Medi-Cal enrollees or to contracts between plans and the federal government for the provision of services to Medicare enrollees.

(2) If a plan has both Medi-Cal and non-Medi-Cal lines of business, then the plan will be in compliance with the requirements of this section as to its non-Medi-Cal lines of business if:

(A) The Medi-Cal standards for providing language assistance services, including standards for timeliness and proficiency of interpreters, are equivalent to or exceed the standards set forth in Section 1367.04 of the Act and this section;

(B) The plan applies the Medi-Cal standards for language assistance programs

to the plan's non-Medi-Cal lines of business; and

(C) The Department of Managed Health Care (Department) determines, as described in Section 1367.04(h)(3) of the Act, that the plan is in compliance with the Medi-Cal standards.

(3) A plan that seeks the Department's determination of compliance as provided in subsection (a)(2) shall request such determination as part of its filing pursuant to subsection (e)(2) and provide documentation sufficient to support and verify the request to the Department's satisfaction. The Department's determination pursuant to subsection (a)(2) shall apply only to the enrollees in a plan's non-Medi-Cal lines of business to which the plan actually applies the plan's Medi-Cal program standards.

(b) Definitions.

(1) Demographic profile means, at a minimum, identification of an enrollee's preferred spoken and written language, race and ethnicity.

(2) Interpretation: the act of listening to something spoken or reading something written in one language (source language) and orally expressing it accurately and with appropriate cultural relevance into another language (target language).

(3) Limited English Proficient or LEP Enrollee: an enrollee who has an inability or a limited ability to speak, read, write, or understand the English language at a level that permits that individual to interact effectively with health care providers or plan employees.

(4) Point of Contact: an instance in which an enrollee accesses the services covered under the plan contract, including administrative and clinical services, and telephonic and in-person contacts.

(5) Threshold Language(s): the language(s) identified by a plan pursuant to Section 1367.04(b)(1)(A) of the Act.

(6) Translation: replacement of a written text from one language (source language) with an equivalent written text in another language (target language).

(7) Vital Documents: the following documents, when produced by the plan (plan-produced documents) including when the production or distribution is delegated by a plan to a contracting health care service provider or administrative services provider:

(A) Applications;

(B) Consent forms, including any form by which an enrollee authorizes or consents to any action by the plan;

(C) Letters containing important information regarding eligibility and participation criteria;

(D) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal;

(E) Notices advising LEP enrollees of the availability of free language assistance and other outreach materials that are provided to enrollees;

(F) A plan's explanation of benefits or similar claim processing information that is sent to an enrollee if the document requires a response from the enrollee; and

(G) Subject to subsection (c)(2)(F)(ii), the enrollee disclosures required by Section 1363(a)(1), (2) and (4) of the Act.

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

(1) Enrollee Assessment. Every health care service plan and specialized health care service plan shall assess its enrollee population to develop a demographic profile and to survey the linguistic needs of individual enrollees. In assessing its enrollee population each plan shall, at a minimum:

(A) Develop a demographic profile of the plan's enrollee population for the purposes of calculating threshold languages and reporting to the Department pursuant to Section 1367.07 of the Act. All plans shall apply statistically valid methods for population analysis in developing the demographic profile and plans may utilize a variety of methods for collecting demographic data for this purpose, including census data, client utilization data from third parties, data from community agencies and third party enrollment processes;

(B) Survey its enrollees in a manner designed to identify the linguistic needs of each of the plan's enrollees, and record the information provided by a responding enrollee in the enrollee's file. Plans may utilize existing processes and methods to distribute the linguistic needs survey, including but not limited to, existing enrollment and renewal processes, subscriber newsletters, mailings and other communication processes. A plan may demonstrate compliance with the survey requirement by distributing to all subscribers, including all individual subscribers under group contracts, a disclosure explaining, in English and in the plan's threshold languages, the availability of free language assistance services and how to inform the plan and relevant providers regarding the preferred spoken and written languages of the subscriber and other enrollees under the subscriber contract; and

(C) Collect, summarize and document enrollee demographic profile data in a manner that enables the plan to maintain confidentiality of personal information and to disclose the information to the Department on request for regulatory purposes and to contracting providers on request for lawful purposes, including language assistance purposes and health care quality improvement purposes. This section is not intended to limit or expand existing law regarding confidentiality of medical records.

(2) Providing Language Assistance Services. Every plan shall develop language assistance program policies and procedures, which shall describe, at a minimum, the information outlined below.

(A) All points of contact where the need for language assistance may be reasonably anticipated.

(B) The types of resources needed to provide effective language assistance to the plan's enrollees.

(C) The plan's processes for informing enrollees of the availability of language assistance services at no charge to enrollees, and how to access language assistance services. At a minimum, these processes shall include the following:



(i) Processes to promote effective identification of LEP enrollee language assistance needs at points of contact, to ensure that LEP enrollees are informed at points of contact that interpretation services are available at no cost to the LEP enrollee, and to facilitate individual enrollee access to interpretation services at points of contact.

(ii) Processes for including the notice required by Section 1367.04(b)(1)(B)(v) with all vital documents, all enrollment materials and all correspondence, if any, from the plan confirming a new or renewed enrollment. If documents are distributed in an LEP enrollee's preferred written language the notice need not be included.

(iii) Processes for including statements, in English and in threshold languages, about the availability of free language assistance services and how to access them, in or with brochures, newsletters, outreach and marketing materials and other materials that are routinely disseminated to the plan's enrollees.

(D) Processes to ensure the plan's language assistance program conforms with the requirements of section 1300.68(b)(3) and (7) of these regulations, including standards to ensure that LEP enrollees receive information regarding their rights to file a grievance and seek an independent medical review in threshold languages and through oral interpretation.

(i) All plans shall ensure that grievance forms and procedures in threshold languages are made readily available to enrollees and to contracting providers for distribution to enrollees upon request.

(ii) All plans shall inform contracting providers that informational notices explaining how enrollees may contact their plan, file a complaint with their plan, obtain assistance from the Department and seek an independent medical review are available in non-English languages through the Department's web site. The notice and translations can be obtained online at [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov) for downloading and printing. In addition, hard copies may be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814.

(E) Processes to ensure that contracting providers are informed regarding the plan's standards and mechanisms for providing language assistance services at no charge to enrollees, and to ensure that LEP language needs information collected by the plan is made available to contracting providers.

(F) Processes and standards for providing translation services, including, but not limited to:

(i) A list of the threshold languages identified by the plan;

(ii) A list of the types of standardized and enrollee-specific vital documents that must be translated and the applicable standards for making translated vital documents available to subscribers and enrollees. Plans need not translate subscriber contracts, evidences of coverage and other large disclosure forms and enrollee handbooks in their entirety, but may excerpt from large documents the disclosures specified at subsection (b)(7)(G) for translation in a format that permits cost-effective and timely production and distribution, so long as there is no loss of accuracy or meaning by doing so. A plan may demonstrate compliance regarding translation of the disclosures specified at subsection (b)(7)(G) if the plan provides a standardized matrix that lists the major categories of health care services

covered under the plan's subscriber contracts, together with the corresponding copayments and coinsurance, and exclusions and limitations, and disclosing any applicable deductibles and lifetime maximums, using the same sequence as the uniform matrix described at Section 1363(b)(1) of the Act.

(iii) A description of how the plan will provide or arrange for the provision of translation of vital documents at no charge to enrollees in accordance with the requirements of Section 1367.04 of the Act and this section. This subsection is not intended to prohibit or discourage a plan from providing translation of vital documents into a greater number of languages than the threshold languages;

(iv) A requirement that non-English translations of vital documents must meet the same standards required for English language versions of those documents; and

(v) A requirement that, with respect to vital documents that are not standardized, but which contain enrollee-specific information, a plan shall provide the English version together with the Department-approved written notice of the availability of interpretation and translation services and, if a translation is requested, the plan shall provide the requested translation in accordance with the requirements of Section 1367.04 of the Act and this section.

(G) Processes and standards for providing individual enrollee access to interpretation services at points of contact at no charge, including, but not limited to:

(i) A list of the non-English languages likely to be encountered among the plan's enrollees.

(ii) A requirement that the plan shall provide LEP enrollees with interpretation services for information contained in plan-produced documents.

(iii) A requirement that qualified interpretation services be offered to LEP enrollees, at no cost to the enrollee, at all points of contact, including when an enrollee is accompanied by a family member or friend that can provide interpretation services. The offer of a qualified interpreter, and the enrollee's refusal if interpretation services are declined, shall be documented in the medical record or plan file, as applicable.

(iv) When an enrollee needs interpretation services at a point of contact that occurs in a hospital, facility or provider office subject to federal or state law that requires the hospital, facility or provider office to provide interpretation services, the plan is not relieved of its obligation to comply with the requirements of Section 1367.04 of the Act or this section. Full service plans shall have reasonable processes in place to ensure that LEP enrollees can obtain the plan's assistance in arranging for the provision of timely interpretation services at all points of contact as defined at subsection (b)(4). This subsection does not prohibit a plan from incorporating into its language assistance program a contracting hospital's language assistance program if: the hospital's language assistance program provides access to interpretation services consistent with the requirements of Section 1367.04 of the Act and this section; the plan monitors for deficiencies in delivery of interpretation services by the hospital; and the plan takes appropriate corrective action to address hospital deficiencies in delivery of interpretation services to the plan's enrollees. This subsection is not intended to limit or expand any existing state or federal law.

(v) A description of the arrangements the plan will make to provide or arrange for the provision of timely interpretation services at no charge to LEP enrollees at all points of contact where language assistance is needed. For purposes of this subsection “timely” means in a manner appropriate for the situation in which language assistance is needed. Interpretation services are not timely if delay results in the effective denial of the service, benefit, or right at issue. A plan’s language assistance program shall specify quality assurance standards for timely delivery of language assistance services for emergency, urgent and routine health care services, and shall include standards for coordinating interpretation services with appointment scheduling.

(vi) The range of interpretation services that will be provided to enrollees as appropriate for the particular point of contact. The range of services may include, but is not limited to:

(aa) Arranging for the availability of bilingual plan or provider staff who are trained and competent in the skill of interpreting;

(bb) Hiring staff interpreters who are trained and competent in the skill of interpreting;

(cc) Contracting with an outside interpreter service for trained and competent interpreters;

(dd) Arranging formally for the services of voluntary community interpreters who are trained and competent in the skill of interpreting; and

(ee) Contracting for telephone, videoconferencing or other telecommunications supported language interpretation services.

(vii) As used in this section, “trained and competent in the skill of interpreting,” “qualified interpretation services” and “qualified interpreter” means that the interpreter meets the plan’s proficiency standards established pursuant to subsection (c)(2)(H).

(H) The plan’s policies and standards for ensuring the proficiency of the individuals providing translation and interpretation services. A plan may develop and apply appropriate criteria for ensuring the proficiency of translation and interpretation services or may adopt certification by an association acceptable to the Department at the time of certification. A plan’s language assistance proficiency standards shall require:

(i) A documented and demonstrated proficiency in both English and the other language;

(ii) A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems; and

(iii) Education and training in interpreting ethics, conduct and confidentiality.

The Department will accept plan standards for interpreter ethics, conduct, and confidentiality that adopt and apply, in full, the standards promulgated by the California Healthcare Interpreters Association or the National Council on Interpreting in Healthcare.

(3) Staff training.

Every plan shall implement a system to provide adequate training regarding the plan’s language assistance program to all plan staff who have routine contact with LEP enrollees. The training shall include instruction on:

(A) Knowledge of the plan’s policies and procedures for language assistance;



- (B) Working effectively with LEP enrollees;
- (C) Working effectively with interpreters in person and through video, telephone and other media, as may be applicable; and
- (D) Understanding the cultural diversity of the plan's enrollee population and sensitivity to cultural differences relevant to delivery of health care interpretation services.

(4) Compliance Monitoring.

(A) Every plan shall monitor its language assistance program, including delegated programs, and make modifications as necessary to ensure compliance with Section 1367.04 of the Act and this section.

(d) In reviewing a plan's proposed language assistance program, the Department will evaluate the totality of the plan's language assistance program to determine whether the program as a whole provides meaningful access for LEP enrollees, and may consider relevant operational and demographic factors, including but not limited to:

(1) Whether the plan is a full service plan or specialized health care service plan;

(2) The nature of the points of contact;

(3) The frequency with which particular languages are encountered;

(4) The type of provider network and methods of health care service delivery;

(5) The variations and character of a plan's service area;

(6) The availability of translation and interpretation services and professionals;

(7) The variations in cost of language assistance services and the impact on affordability of health care coverage; and

(8) A plan's implementation of best practices and utilization of existing and emerging technologies to increase access to language assistance services, such as video interpreting programs, language translation software, collaborating with other plans to share a pool of interpreters, and other methods and technologies.

(9) Specialized dental, vision, chiropractic, acupuncture and employee assistance program plans that demonstrate adequate availability and accessibility of qualified bilingual contracted providers and office staff to provide meaningful access to LEP enrollees, will be in compliance with the requirements of subsection (c)(2)(G)(iii) and (v). For the purposes of this subsection, specialized dental, vision, chiropractic, acupuncture and employee assistance program plans may demonstrate adequate availability and accessibility of competent and qualified bilingual providers and office staff if:

(A) The plan identifies within its provider directories those contracting providers who are themselves bilingual or who employ other bilingual providers and/or office staff, based on language capability disclosure forms signed by the bilingual providers and/or office staff, attesting to their fluency in languages other than English;

(B) The plan requires all contracting providers to provide quarterly updates regarding any changes in the language capabilities of currently employed providers and/or office staff by submitting new language capability disclosure forms, and the plan updates its provider directories accordingly, and consistent with Section 1367.26 of the Act; and

(C) The plan's quality assurance audits of contracting providers confirm and

document the accuracy of provider language capability disclosure forms and attestations.

(e) Implementation.

(1) Within one year of the effective date of this section, every plan shall complete the initial enrollee assessment required by Section 1367.04 of the Act and this section. Every plan shall update its assessment of enrollee language needs and enrollee demographic profile at least once every three years following the initial assessment.

(2) By July 1, 2008, every plan shall file, in accordance with Section 1352 of the Act, an amendment to its quality assurance program providing its written language assistance program policies and procedures, together with information and documents sufficient to demonstrate compliance with the requirements and standards of Section 1367.04 of the Act and this section. The filing shall include the plan's Section 1367.04(b)(1)(B)(v) notices. All materials filed with the Department that contain documents in non-English languages shall include the following minimum supporting documentation:

(i) The English version of each non-English document

(ii) An attestation by the translator or, if applicable, by an authorized officer of the organization providing translator services, outlining the qualifications of the translator making the translation and affirming that the non-English translation is an accurate translation of the English version.

(3) By January 1, 2009 every plan shall have established and implemented a language assistance program in compliance with the requirements of Section 1367.04 of the Act and this section.

(4) Every contract between a health care provider and a plan, including a specialized plan, that is issued, amended, delivered or renewed on or after January 1, 2009, shall require compliance with the plan's language assistance program standards developed pursuant to Section 1367.04 of the Act and this section.

(A) A plan shall retain financial responsibility for the implementation of the language assistance program required by Section 1367.04 of the Act and this section, except to the extent that delegated financial responsibility has been separately negotiated and specifically documented in written contracts. This subsection does not create an exception to Section 1367 of the Act and delegation shall not constitute a waiver of the plan's obligation to provide language assistance services required by Section 1367.04 of the Act and this section.

(B) Delegation to contracting providers of any part of the plan's obligation to provide language assistance services required by Section 1367.04 of the Act and this section constitutes a material change to a provider contract subject to the requirements of Section 1375.7 of the Act.

(f) The Department will periodically review plan compliance with the standards and requirements of Section 1367.04 of the Act and this section by methods that may include, but are not limited to, the medical survey process, reviews of consumer grievances and complaints to the Department's HMO Help Center, and provider complaints submitted to the Department's provider complaint line. The Department may also periodically request that plans submit information and data regarding enrollee language needs and demographic profile.

**28 CCR 1300.68(b)(3) and (7)**

(b) The plan's grievance system shall include the following:

(3) The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. Plans shall develop and file with the Department a policy describing how they ensure that their grievance system complies with this subsection within 90 days of the effective date of this regulation.

...

(7) Grievance forms and a description of the grievance procedure shall be readily available at each facility of the plan, on the plan's website, and from each contracting provider's office or facility. Grievance forms shall be provided promptly upon request.

**28 CCR 1300.70**

(a) Intent and Regulatory Purpose.

(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

(2) This section is not intended to set forth a prescriptive approach to QA methodology. This section is intended to afford each plan flexibility in meeting Act quality of care requirements.

(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

(4) The Department's assessment of a plan's QA program will focus on:

(A) the scope of QA activities within the organization;

(B) the structure of the program itself and its relationship to the plan's administrative structure;

(C) the operation of the QA program; and

(D) the level of activity of the program and its effectiveness in identifying and correcting deficiencies in care.

(b) Quality Assurance Program Structure and Requirements.

(1) Program Structure.

To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:

(A) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees;

(B) quality of care problems are identified and corrected for all provider entities;

(C) physicians (or in the case of specialized plans, dentists, optometrists,

psychologists or other appropriate licensed professionals) who provide care to the plan's enrollees are an integral part of the QA program;

(D) appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan providers, and/or others; and

(E) the plan does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor to pressure health care providers or institutions to render care beyond the scope of their training or experience.

(2) Program Requirements.

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

(A) There must be a written QA plan describing the goals and objectives of the program and organization arrangements, including staffing, the methodology for on-going monitoring and evaluation of health services, the scope of the program, and required levels of activity.

(B) Written documents shall delineate QA authority, function and responsibility, and provide evidence that the plan has established quality assurance activities and that the plan's governing body has approved the QA Program. To the extent that a plan's QA responsibilities are delegated within the plan or to a contracting provider, the plan documents shall provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.

(C) The plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components which the QA program has identified as presenting significant or chronic quality of care issues.

(D) Implementation of the QA program shall be supervised by a designated physician(s), or in the case of specialized plans, a designated dentist(s), optometrist(s), psychologist(s) or other licensed professional provider, as appropriate.

(E) Physician, dentist, optometrist, psychologist or other appropriate licensed professional participation in QA activity must be adequate to monitor the full scope of clinical services rendered, resolve problems and ensure that corrective action is taken when indicated. An appropriate range of specialist providers shall also be involved.

(F) There must be administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out their assigned QA activities for

the plan and delegated entities.

(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees. If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

(1) Inform each provider of the plan's QA program, of the scope of that provider's QA responsibilities, and how it will be monitored by the plan.

(2) Ascertain that each provider to which QA responsibilities have been delegated has an in-place mechanism to fulfill its responsibilities, including administrative capacity, technical expertise and budgetary resources.

(3) Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.

(4) Require that standards for evaluating that enrollees receive health care consistent with professionally recognized standards of practice are included in the provider's QA program, and be assured of the entity's continued adherence to these standards.

(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.

(6) Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.

(H) A plan that has capitation or risk-sharing contracts must:

1. Ensure that each contracting provider has the administrative and financial capacity to meet its contractual obligations; the plan shall have systems in place to monitor QA functions.

2. Have a mechanism to detect and correct under-service by an at-risk provider (as determined by its patient mix), including possible under utilization of specialist services and preventive health care services.

(I) Inpatient Care.

1. A plan must have a mechanism to oversee the quality of care provided in an inpatient setting to its enrollees which monitors that:

a. providers utilize equipment and facilities appropriate to the care; and

b. if hospital services are fully capitated that appropriate referral procedures are in place and utilized for services not customarily provided at that hospital.

2. The plan may delegate inpatient QA functions to hospitals, and may rely on the hospital's existing QA system to perform QA functions. If a plan does delegate QA responsibilities to a hospital, the plan must ascertain that the hospital's quality assurance procedure will specifically review hospital services provided to the plan's enrollees, and will review services provided by plan physicians within the hospital in the same manner as other physician services are reviewed.

(c) In addition to the internal quality of care review system, a plan shall design

and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the Department.