Second Biennial Report to the Legislature on Language Assistance

July 1, 2011

DEPARTMENT OF
Managed
Health Care

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EXECUTIVE SUMMARY

In 2003, the California Legislature passed Senate Bill 853 (SB 853) which, in part, required the Department of Managed Health Care (DMHC) to develop regulations that require health plans to provide language assistance services, including specified translation and interpretation services, to limited-English-proficient (LEP) enrollees. Between 2004 and 2007, the DMHC led efforts to develop regulations that ensure that LEP enrollees in all health care service plans (health plans or plans) receive appropriate language assistance services. The result was the set of language assistance regulations codified at section 1300.67.04 of title 28 of the California Code of Regulations (language assistance regulations).

The language assistance regulations require health plans to conduct periodic enrollee assessments to evaluate the linguistic needs of their enrollee populations, maintain policies and procedures to ensure that LEP enrollees are able to access language assistance services, instruct staff on the use of the language assistance services, and monitor the plans' operations and services to ensure compliance with the language assistance regulations.

Under the language assistance regulations, 82 active health plans licensed by the DMHC were required to conduct an enrollee assessment of linguistic needs, submit language assistance policies and procedures that demonstrated that the plans would be compliant with the Language Assistance regulations by January 1, 2009, and fully implement those policies and procedures by January 1, 2009.

The DMHC reviewed all of the language assistance policies and procedures submitted by the 82 health plans to ensure that they met the guidelines specified in the language assistance regulations. To assess whether the health plans have actually implemented those policies and procedures, the DMHC integrated the language assistance regulations into the routine survey audit tools and incorporated a review of health plan compliance with the language assistance regulations within the statutorily-mandated three-year routine survey cycle.[1] The DMHC's routine medical surveys began reviewing for health plan compliance with the language assistance regulations on January 1, 2009.

Additionally, the DMHC tracks consumer complaints filed with its Help Center to identify enrollees who had difficulty accessing language assistance services through their health plans and provider offices.

The DMHC completed 43 routine medical surveys that included a review of plan compliance with the language assistance standards. In 2009, the surveys confirmed that the plans had dedicated resources to educate plan staff and providers on language assistance regulations. In 2010, the DMHC's surveys began to cite plans for deficiencies regarding their inability to consistently provide enrollees with access to qualified interpreters at their member services departments, provider offices, and contracted hospitals. The DMHC also provided advice and assistance to the plans for continued improvements and amendments in the plans' language assistance program documents and procedures.

For each deficiency cited, the DMHC confirmed in follow-up surveys that the health plan corrected the deficiency within a reasonable amount of time. To date, there have been no serious problems or concerns identified regarding the implementation of the language assistance regulations, and no enforcement actions associated with non-compliance with language assistance standards have been necessary.

INTRODUCTION

The California Legislature established the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) to regulate managed health care service plans in order to ensure that their enrollees have access to basic health care services. Initially, the Department of Corporations served as the agency responsible for carrying out the regulatory functions of the Knox-Keene Act, which includes licensing and overseeing these health plans. However, in 2000, amendments to the Knox-Keene Act created the California Department of Managed Health Care (DMHC) as the regulatory body responsible for these regulatory functions. Health plans licensed by the DMHC provide health care services, including medical, behavioral health, dental, chiropractic, vision, and pharmacy, to approximately 70 million of California's increasingly diverse population.

In 2003, the California Legislature passed Senate Bill 853,[2] which sought to improve health care access for non-English-speaking and LEP individuals enrolled in health plans regulated by the Department of Insurance (CDI) or the DMHC. SB 853 modified the Health and Safety Code by amending existing Section 1367 and adding Sections 1367.04 and 1367.07. These provisions outline basic guarantees of the language assistance services that must be provided by DMHC-licensed health plans. SB 853 also directed the DMHC to adopt appropriate regulations to ensure that health plans provide language translation and interpretation services to enrollees at no charge.

In order to implement effective language assistance regulations, the DMHC collaborated with advocates for consumers, health plans, and health care providers. In 2007, after an extensive rulemaking process, the DMHC promulgated regulations that obligated health plans, by January 1, 2009, to:

- Meet regulatory deadlines for achieving certain language assistance implementation milestones
- Assess the linguistic needs of enrollees
- Provide translation and interpretation services to all enrollees
- Train staff in effectively providing services to enrollees
- Provide oversight to ensure that enrollees receive the language assistance services they need in order to understand and communicate with health care providers[3]

SB 853 also required all DMHC-licensed health plans to submit a one-time "Cultural Appropriateness Report" to the DMHC after the implementation of the language assistance regulations.[4] The Cultural Appropriateness Report was required to contain general information regarding the plan's internal policies and procedures related to cultural appropriateness in several contexts.

The DMHC is statutorily required to provide biennial reports to the Legislature on health plan compliance with the standards and regulations developed under Section 1367.04. The First Biennial Report to the Legislature on Language Assistance was filed on July 1, 2009, and provided an overview of the early phases of the DMHC's oversight of the plans' implementation efforts.

This Second Biennial Report to the Legislature on Language Assistance covers the period between January 1, 2009, and December 31, 2010, and updates the status of plan compliance efforts with language assistance standards. The information in this report was gathered through the DMHC's routine medical surveys of 43 full-service and specialized plans, and through the aggregation and analysis of consumer complaints submitted through the DMHC's Help Center during those 24 months.

Table 1 provides a 24-month overview of the number of calls and formal complaints filed with the DMHC's Help Center related to the language assistance regulations. The most common consumer inquiry concerned access to translation and interpreter services. The Help Center's call center is equipped to quickly provide information to consumers on accessing these services through their health plans, and can facilitate communication between the consumer and the health plan to promptly arrange language services, when needed.

Table 1: Language Assistance Issues Handled by the DMHC's Help Center (January 1, 2009, through December 31, 2010)

Type of Issue	Number of Calls	Number of Formal Complaints
Consumer – Inquiry about how to obtain translated documents	31	4
Consumer – Inquiry about how to obtain an interpreter	26	1
Consumer – Inquiry about the language assistance laws	39	0
Consumer – Requested interpreter, but none was provided	9	3
Provider – Unsure how to access a plan's language assistance program	7	0
Provider – Inquiry about the language assistance laws	19	0
General – Inquiry about how to become employed as an interpreter	20	0
Total Number of Calls and Formal Complaints Regarding Language Assistance	**151**	**8**
Total Number of Calls Received by the Help Center	**163,287**	**13,611**

Information current as of April 8, 2011

The DMHC's oversight efforts reveal an ongoing need to educate health plans and their providers of the expectations of the language assistance standards and requirements, so that both entities may implement and carry out their mandated functions smoothly. These functions include ensuring that language assistance provided to enrollees meets specified proficiency standards, that it is available to enrollees at provider offices and hospitals, and that it is offered to all enrollees, even when friends or family members who can interpret accompany the enrollee.

The DMHC's oversight efforts also reveal an ongoing need to educate enrollees about their rights under the language assistance regulations. Enrollees need reminders of their ability to request language assistance services from their health plans' member services departments or from their health plans' provider offices. Enrollees also need to understand their plans' obligations to provide free language assistance services and that those services should be easily accessible upon request.

Pursuant to Health and Safety Code section 1367.04(g), this report summarizes the DMHC's findings regarding plan compliance with the language assistance standards. Part I of this report describes the regulatory requirements for each plan's language assistance program. Part II provides information regarding health plan compliance with the language assistance regulations, based on survey results. Part III of this report provides an overview of the Cultural Appropriateness Report that all plans were required to complete. Part IV includes the DMHC's comments and recommendations for consideration.

PART I: LANGUAGE ASSISTANCE REGULATION REQUIREMENTS

Throughout the development of the language assistance regulations, the DMHC collaborated with a number of stakeholder groups to ensure that the requirements placed on health plans were reasonable, workable, and effective in providing language services to LEP enrollees.

The resulting regulations, adopted in Rule 1300.67.04, create an extensive set of requirements that health care plans must now meet.[5] These regulations fall into the general categories discussed below.

Reporting Deadlines

The regulations recognized that health plans would require time to implement these new standards. To ensure that health plans were actively engaged with the regulations and working to fully comply with the law, the statutes and regulations contained certain milestone deadlines:

- By February 23, 2008, health plans were required to complete an initial assessment of the linguistic needs of their enrollee populations.[6]
- By July 1, 2008, health plans were required to file a "Language Assistance Program" containing policies and procedures that demonstrated the plan's compliance with the language assistance regulations.[7]
- By January 1, 2009, health plans were required to have fully implemented their language assistance programs and be fully compliant with the language assistance regulations.[8]
- Within one year of completing the initial enrollee assessment, health plans were required to complete a report on cultural appropriateness containing summaries of the following:
    - How the plan surveys its enrollee population
    - How the plan trains staff who have routine contact with enrollees about the diverse needs of the enrollee population
    - How the plan's recruitment and retention efforts encourage workforce diversity
    - How the plan evaluates its programs and services with respect to its enrollee population
    - How the plan periodically provides information to plan providers regarding the ethnic diversity of the plans' enrollee population and any related strategies
    - How the plan periodically provides educational information to its enrollees about its services and programs.[9]

- In addition to the above deadlines, plans are required to update the assessment of the linguistic needs of their enrollee populations every three years.[10]

Enrollee Assessment

Determination of Threshold Languages through Population Analysis

Recognizing that health plans often serve different and diverse communities, Section 1367.04 provides health plans with a limited ability to tailor language assistance services to the reality of each plan's enrollee population. Each health plan was required to complete an initial assessment of the linguistic needs of its enrollee population by March 2008.[11] Under the regulations, based on the plan's size and language needs assessment, the plan determined its "threshold languages".[12] The statute requires the translation of vital documents into the plan's threshold languages. (See "Language Assistance Services" below.)

Criteria for determining a plan's threshold languages are defined in Section 1367.04(b)(1)(A)(i-iii). Table 2 summarizes the criteria for determining a plan's threshold language(s):

Table 2: Threshold Language Criteria[13]

Number of Enrollees in the Health Plan	Minimum Number of non-English Threshold Languages	Additional Threshold Languages if Either of These are Met:	
		Percent of Total Enrollees in a LEP Group	Total Number of LEP Enrollees in a LEP Group
> 1,000,000	2 languages	0.75%	15,000
300,000 – 1,000,000	1 language	1.0%	6,000
< 300,000[14]	0 languages	5.0%	3,000

Each plan's initial assessment was required to be based on statistically valid population analysis methods, and plans were required to collect and record enrollees' language data using reasonable survey methods.[15] Plans must also use valid population analysis methods to update the enrollee language needs assessment at least once every three years after the initial assessment.

Enrollee Surveys

In addition to determining threshold languages through population analysis, health plans were also required to distribute individual surveys to their enrollees in order to identify their individual linguistic needs. Health plans were required to record each enrollee's response in the enrollee's file, in a manner that maintains the confidentiality of the information.[16] The health plans all completed both the determination of threshold languages and the individual linguistic needs surveys by March 2008.

Ongoing Assessments

After completion of the initial enrollee assessments in February 2008, health plans must update the needs assessment, demographic profile, and language translation (threshold languages) requirements every three years.[17] The health plans began updating their enrollee assessments in February 2011. This ongoing assessment requirement was added to the DMHC's medical routine survey beginning in February 2011.

Language Assistance Services

The language assistance regulations required health plans, by July 1, 2008, to develop extensive policies and procedures, including specified sections, describing how they would provide effective language assistance services at all points of contact where language assistance might be reasonably anticipated.[18]

Assessment of Services

Health plans were required to assess and describe all points of contact where the need for language assistance might reasonably arise. In addition, plans were required to independently assess and describe the resources necessary to provide those services to enrollees, and to describe the steps they would take to notify enrollees of the availability of free language assistance services at those points of contact.

Translation Services

For the purposes of the language assistance regulations, the term "translation" refers to the conversion of a document written in a source language to a document written in a target language. Plans must provide translation services for their identified threshold languages, as determined by the periodic enrollee assessment, described above.

The documents that plans must translate are termed "Vital Documents,"[19] and include:

- Applications
- Consent forms, including any form by which an enrollee authorizes or consents to any action by the plan
- Letters containing important information regarding eligibility and participation criteria
- Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal
- Notices advising LEP enrollees of the availability of free language assistance and other outreach materials that are provided to enrollees
- The explanation of benefits (EOB) or similar claim processing information that is sent to an enrollee if the document requires a response from the enrollee
- Specified portions of the plan's disclosure forms regarding the principal benefits and coverage, exclusions, limitations, and cost-sharing requirements applicable under a plan contract.[20]

Vital documents must be translated into the enrollee's preferred language if it is one of the plan's threshold languages. If a vital document contains a section that is enrollee-specific and tailored to the specific circumstances of the enrollee, a health plan is not required to automatically translate the non-standardized portion of the document. However, the plan must provide the enrollee notice of the availability of language assistance services with the non-standardized document. If the enrollee requests translation, the translated document must be provided to the enrollee within 21 days.[21] The language assistance regulations require that non-English translations of vital documents must preserve the accuracy or meaning of the information provided in the English language version of those documents, and must meet the various Knox-Keene Act content requirements.

Interpretation Services

Interpretation services must be provided to enrollees at all plan points of contact where the enrollee might reasonably need such services.[22] For purposes of the language assistance regulations, the term "interpretation" refers to the conversion of a verbal communication or a written document into a verbal communication in a target language.[23] Plans are required to provide interpretation services for *any* language requested by an enrollee, irrespective of whether the language is identified as one of the plan's threshold languages.[24]

Although the range of interpretation services to be provided is not specified in the regulation, the range of services available must be appropriate for the particular point of contact.[25] The regulation provides examples of some of the services that may be provided by the plan:

- Arranging for the availability of bilingual plan or provider staff
- Hiring staff interpreters who are trained and competent in interpreting
- Contracting with trained and competent interpreters
- Formally arranging for the services of voluntary community interpreters who are trained and competent in interpreting
- Contracting for telephone, videoconferencing, or other telecommunication-based language services[26]

Interpretation services must be offered to the enrollee even if the enrollee is accompanied by a family member or friend who is able to provide interpretation services. If the enrollee declines the service, the declined offer must be noted in the enrollee's file.[27]

Notice of the Availability of Language Assistance Services

Health plans must have processes for including the notice of the availability of free language assistance services with the following documents: all English versions of the plan's vital documents, all enrollment materials, all correspondence from the plan confirming a new or renewed enrollment, brochures, newsletters, outreach and marketing materials, and other materials routinely disseminated to enrollees. Health plans may develop their own language assistance notices, subject to the DMHC's approval, that include information sufficient to advise LEP enrollees of the availability of free language assistance services.[28]

To assist the health plans in meeting the notice requirements, the DMHC developed the following sample notice:

> **IMPORTANT**: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to ask about written information in (your language), first call your health plan's phone number at 1-XXX-XXX-XXXX. Someone who speaks (your language) can help you. If you need more help, call the DMHC Help Center at 1-888-466-2219.

The DMHC funded and posted on its public website the translation of the above language assistance notice in Spanish, Chinese (traditional), Arabic, Armenian, Khmer, Farsi, Hmong, Korean, Laotian, Russian, Tagalog, and Vietnamese.[29]

Health plans are encouraged to use these notices even if some of the languages are not among their threshold languages. During the DMHC's review of plan filings, analysts confirmed that many health plans were using the DMHC's notice (or slightly modified versions of the notice) to achieve compliance with the notice requirements. The CDI has also issued similar notices for health insurance plans.[30]

Quality of Services

Proficiency Standards

The language assistance regulations also require plans to have policies and procedures that ensure the proficiency of individuals or organizations providing translation and interpretation services.

Plans must either develop and apply appropriate criteria for ensuring the proficiency of translation and interpretation services, or they must adopt certification by an association acceptable to the DMHC.[31] At a minimum, a plan's language proficiency standards must require that its interpreters have:

- A documented and demonstrated proficiency in both English and the target language
- A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems

- Education and training in interpreting ethics, conduct, and confidentiality (The DMHC accepts 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.)[32]

Access to Qualified Interpreters

Plans must have policies and procedures for providing enrollees with access to interpretation services at points of contact, at no charge, including, but not limited to:

- A list of the non-English languages likely to be encountered among the plan's enrollees
- A description of how the plan will provide LEP enrollees with interpretation services for information contained in plan-produced documents
- A description of how qualified interpreters will be offered to LEP enrollees at points of contact
- A description of the arrangements the plan will make to provide or arrange for timely interpreter services

The plans must provide language assistance services within the timeframes appropriate for the situation in which language assistance is needed.[33] In addition, a plan's language assistance program must specify quality assurance standards for timely delivery of language assistance services for emergency, urgent, and routine health care services, and must include standards for coordinating interpretation services with appointment scheduling.[34]

Specialized plans providing dental, vision, chiropractic, acupuncture or employee assistance services may demonstrate that their bilingual providers and office staff are (1) adequately available and accessible, and (2) competent and qualified if:

- The plan identifies within its provider directories those contracting providers who are bilingual or who employ bilingual providers and/or staff. The plan may determine the provider's bilingual abilities by requiring completion of language capability disclosure forms signed by the bilingual providers and/or office staff. These disclosure forms would require the bilingual providers and/or office staff to attest to their fluency in languages other than English[35]
- The plan requires all contracting providers to provide quarterly updates regarding any changes in the language capabilities of currently employed providers[36]
- The plan's quality assurance audits of contracting providers confirm and document the accuracy of provider language capability disclosure forms and attestations.[37]

Staff Training

Plans must deliver language assistance training to all Plan staff who have routine contact with LEP enrollees.[38] The basic topics that health plans must cover in their training include:

- Knowledge of the plan's policies and procedures for language assistance
- Working effectively with LEP enrollees
- Working effectively with interpreters in person and through video, telephone, and other media as may be applicable
- Understanding the cultural diversity of the plan's enrollee population
- Sensitivity to cultural differences relevant to delivery of health care interpretation services[39]

Compliance Monitoring

Health plans must have policies and procedures to: (1) monitor their language assistance programs, including the parts of their programs that have been delegated to their providers; and (2) to make modifications to their programs, and any delegated parts of their programs, to ensure compliance with the language assistance regulations.[40] The requirements for the plans to monitor and ensure the delivery of language assistance services to their enrollees through the plans' member services departments, provider offices, and contracted hospitals were included within the plans' quality assurance programs.

Medi-Cal Deeming

Health plans that participate in California's Medi-Cal program were already required to provide language assistance services. The Medi-Cali requirements generally meet or exceed the Knox-Keene Act's standards for language assistance. In recognition of this, the regulations allow the DMHC to deem health plans that comply with Medi-Cal's language assistance requirements to be compliant with the Knox-Keene Act's requirements,[41] if:

- The plan makes a request to be considered in compliance because of its adherence to the Medi-Cal standards
- The Medi-Cal standards are equivalent to or exceed the standards of the regulations
- The plan applies the Medi-Cal standards for to the plan's non-Medi-Cal lines of business[42]

PART II: PLAN COMPLIANCE WITH STANDARDS

The DMHC's Surveys of Health Care Service Plans: Compliance with Language Assistance Regulations and Standards

Overview

The Help Center's Plan Surveys Division conducts routine onsite medical surveys/compliance audits of each health plan licensed under the Knox-Keene Act at least once every three years. Beginning in January 2009, the DMHC incorporated a compliance review of each health plan's language assistance program into the routine medical survey. The aggregate results of the 43 completed routine medical surveys from January 1, 2009, to December 31, 2010, identified a total of 15 deficiencies[43] and 26 recommendations.[44]

Specialized dental and vision plans were responsible for the largest number of deficiencies, accounting for 12 out of 15 total deficiencies (see further discussion below). While no specific cause for these deficiencies was identified, some possible explanations may include the fact that: (1) specialized plans have smaller enrollment and fewer resources; and (2) specialized plans have proportionately more individual provider offices, making outreach more fragmented.

In 2009, the plans were in the early stage of language assistance program implementation. Accordingly, the focus of the first round of surveys was to assess the plans' implementation efforts and to verify that they were allocating sufficient resources to ensure that the regulatory requirements were timely and correctly implemented.

In 2010, the surveys began to substantively assess whether the plans' were fully compliant with the regulatory requirements. The surveys specifically evaluated whether:

- The plans' bilingual providers and office staff were easily identifiable
- The plans were using vendors to provide interpreter services at all points of contact
- The plans were overseeing and verifying the proficiency of bilingual staff and services provided in provider offices, if the plans had any bilingual staff at those provider offices
- The plans were overseeing and verifying the proficiency of bilingual provider staff and services provided in provider offices, if the plans allowed providers to provide language assistance at those offices.

Of the 15 total deficiencies cited between 2009 and 2010, noting areas of non-compliance with the Knox-Keene Act, 14 were cited during the 2010 routine medical surveys.

The most common health plan deficiencies found in the routine medical surveys were:

- The failure to properly train provider groups and offices on the plan's language assistance program requirements;
- The failure to arrange for the provision of language assistance at all points of contact
- The failure to ensure the proficiency of the interpreter services provided to plan enrollees

Of the 26 recommendations offered to enhance and support compliance, the majority (12) focused on compliance monitoring. Generally, the DMHC recommended that plans:

- Improve oversight of the proficiency of bilingual office staff
- Refine criteria used in audit tools to verify proficiency
- Ensure that providers comply with the plan's language assistance program

Survey Results

Since all plans are required to comply with the language assistance regulations, all 43 surveys conducted in 2009 and 2010 assessed plan compliance.. The size and type of the health plans vary from more than a million commercial enrollees to plans with enrollment smaller than 10,000 commercial enrollees. The DMHC surveyed full service plans and specialized plans offering vision, dental, or behavioral health services (see Table 3).

Table 3: Number of Surveys Completed by Year

Health Plan Type	2009	2010
Full Service	8	6
Dental	4	8
Behavioral Health	6	5
Vision	0	4
Chiropractic	2	0
Total	**20**	**23**

Total of 43 Routine Surveys 1/1/2009 – 12/31/2010

Table 4 identifies the health plans surveyed in 2009 and 2010:

Table 4: List of Health Plans Surveyed

2009 Surveys	2010 Surveys
Full Service	**Full Service**
• Blue Shield	• HealthNet
• Aetna	• Santa Clara County
• Cigna	• Chinese Community
• Sharp	• Scripps Clinic
• Heritage	• Blue Cross
• County of Ventura	• Care 1st
• County of Los Angeles	**Dental**
• PrimeCare	• Access Dental
Dental	• United Concordia
• Managed Dental	• Blue Cross
• Dental Benefits Providers	• Safeguard Dental
• California Dental	• California Benefits Dental
• Consumer Health	• Cigna Dental
Behavioral Health	• UDC Central
• Human Affairs International	• Aetna Dental
• Magellan	**Behavioral Health**
• Managed Health Network	• Empathia Pacific
• United Behavioral Health	• Health & Human Resources
• PacifiCare	• Holman Professional
• Concern (EAP)	• Blue Cross
	• Cigna

Survey Results by Plan Type

Table 5 identifies the number of deficiencies and recommendations by health plan type. Ninety-three percent (14 of 15) of the deficiencies were cited in 2010.

- Dental plans received 46 percent (7) of the 15 deficiencies cited over the two years,
- Vision plans received 33 percent (5) of the 15 deficiencies cited the over two years.

Table 5: Deficiencies and Recommendations by Health Plan Type

Health Plan Type	Deficiencies	Recommendations
Full Service	2	2
Dental	7	9
Behavioral Health	1	5
Vision	5	10
Chiropractic	0	0
Total	**15**	**26**

Table 6 identifies the deficiencies and recommendations by the size of the plans' commercial enrollment (including the Healthy Families Program) and illustrates the disproportionately high number of language assistance deficiencies in plans with fewer than 500,000 enrollees. The majority of plans in this category are dental and vision plans that typically charge lower premiums.

Table 6: Survey Deficiencies and Recommendations by Health Plan Enrollment

Health Plan Enrollment	Deficiencies	Recommendations
Large (more than 500,000 enrollees)	1	1
Medium (150,000 to 499,999 enrollees)	5	7
Small (fewer than 150,000 enrollees)	9	18
Total	**15**	**26**

Survey Results by Standards Category

Table 7 identifies the deficiencies and recommendations relating to the four primary language assistance program elements: 1) standards for enrollee assessment, 2) standards for language assistance services, 3) standards for staff training, and 4) standards for compliance monitoring. The plans' language assistance programs must address each of these four standards.

The standards for enrollee assessment require each health plan to assess its enrollee population in order to develop a demographic profile of its enrollment (which is used to identify the most commonly spoken languages), and to survey the linguistic needs of their individual enrollees. The standards specify the methodology that each plan may utilize in assessing its enrollee population and conducting the individual enrollee surveys.[45]

The standards for language assistance services require each health plan to establish policies and procedures in order to provide language assistance services to enrollees at all points of contact, such as the member services department, the provider offices, and hospitals. In addition, these standards require the plan to inform enrollees of the availability of language assistance services and how to access them. Plans must also specify which documents are automatically translated, inform contracted providers of language assistance services offered, and ensure that the services offered meet specified proficiency standards.[46]

The standards for staff training require each health plan to implement a system that provides adequate training regarding the plan's language assistance program to all plan staff that have routine contact with LEP enrollees. The training must include instruction on the plan's language assistance policies and procedures; working with LEP enrollees; working with interpreters through various ways, such as video or telephone; and understanding how the diversity of the enrollee population affects the delivery of health care services.[47]

The standards for compliance monitoring require each health plan to monitor and make any necessary modifications to its language assistance program, as well as any part of the program that it has delegated to its providers or other entities.[48]

The standards for the delivery of language assistance services and the standards for compliance monitoring were the most problematic for health plans. Educational outreach to providers, resource assessments, and recruitment efforts also presented challenges. This appears to be due, in part, to the complexity of the language assistance requirements, which plans have difficulty in interpreting, and to the lack of resources dedicated to the program by plans with fewer than 500,000 enrollees. Additionally, even after one to two years of implementation, the plans' internal compliance monitoring processes are still in the early stages of development. This delay appears to be due to the numerous provider offices of those specialized plans that lack sufficient resources to adequately monitor them all. In future reports, the DMHC expects to see improved results in both the delivery of services and in compliance monitoring.

Table 7: Survey Deficiencies and Recommendations by Language Standard

Language Standard	Deficiencies	Recommendations
1. Standards for Compliance Monitoring	7	12
2. Standards for Language Assistance Services	8	8
3. Standards for Staff Training	0	4
4. Standards for Enrollee Assessment	0	2
Total	**15**	**26**

Survey Overview of Standards for Compliance Monitoring

With seven deficiencies and twelve recommendations, this area appeared to be the most problematic. As plans transitioned from implementing operational requirements to monitoring their implementation efforts, the two most common oversights were:

- The plan's inability to ensure that language assistance services are offered at all points of contact (four deficiencies)

- The plan's inability to adequately monitor provider compliance with its language assistance program (three deficiencies)

The surveys examined each plan's program documents and operations to confirm the existence of adequate oversight safeguards to ensure compliance, and confirmed whether the plan had designated a person or department to be primarily responsible for oversight of its program.

The twelve recommendations focused on improving plan systems and processes to support oversight of the delivery of language assistance services. Among these twelve recommendations, the four most common were to:

- Audit methodologies and schedule follow-up with the providers' bilingual office staff to ensure proficiency
- Establish feedback mechanisms between specialized dental and vision plans to the full service plan
- Develop assessment tools to evaluate interpreter qualifications
- Continue communications to the providers about the language assistance regulations

Survey Overview of Standards for Language Assistance Services

The surveys examined each plan's policies and procedures for informing enrollees of the availability of free language assistance services, and for providing translation and interpretation services. To ensure that plans were informing enrollees of these services, the DMHC identified "vital documents," as deemed by the language assistance regulations and by the plans, and assessed whether these documents were provided to the enrollees with notices that informed them of the availability of free language assistance services.[49] Vital documents include applications, consent forms, notices pertaining to denial or modification of services or benefits, grievance letters, and other plan correspondence.

The surveys also examined the plans' policies and procedures for ensuring the quality, accuracy, and timeliness of translation and interpretation services; and for ensuring that the plan's grievance system addresses the linguistic and cultural needs of its enrollees.

Eight deficiencies and eight recommendations were identified in these areas. The eight deficiencies are as follows:

- Three deficiencies for failure to ensure the proficiency of language vendors and bilingual staff
- Two deficiencies for failing to include the notice of interpreter and translation availability and responding to requests for translations of grievance correspondence or utilization management letters
- Three deficiencies for failing to ensure that providers are educated and contracts are amended to ensure provider compliance with the plan's LEP standards, e.g., offering interpreter services even when family members are present to interpret, and documenting language preferences in enrollee records.

The surveys also recommended that plans expand their efforts to inform enrollees that language assistance services are available (1) for document translation, (2) during appointments, and (3) for completing online grievance forms.

Survey Overview of Standards for Staff Training

The surveys examined the language assistance training program for staff who routinely have contact with LEP enrollees, including identifying all specified plan staff, evaluating the training program for essential elements, and ensuring that new staff receives training and periodic retraining.

Here, it appears that none of the health plans had any deficiencies. However, the DMHC did provide four recommendations in this area. These recommendations correspond to one of the following: (1) revise policies and procedures to specify the time interval for periodic staff training, (2) revise training guidelines to reflect an understanding of cultural diversity, or (3) revise policies and procedures and train staff to document an enrollee's refusal of language assistance services.

Survey Overview of Standards for Enrollee Assessment

To evaluate each plan's compliance with standards for enrollee assessment (see above discussion on standards for enrollee assessment), the DMHC surveyed each plan's processes for assessing the linguistic needs of its enrollee population. Generally, the health plans complied with the standards for enrollee assessment. This is not surprising because the plans already received DMHC feedback on their initial enrollee assessment efforts in July 2008. The two recommendations cited involved policy amendments to more accurately reflect the plans' operations in their enrollee assessment processes.

Survey Recommendations

The greatest challenges noted over the past two years of surveys were found among small- to medium-sized specialized plans, and centered around the plans' efforts to: (1) educate providers on their obligation to provide language assistance, (2) inform the public of the availability of language assistance, (3) coordinate the arrangement of qualified interpreter services within the plans' health care delivery system, and (4) oversee and ensure the quality and timeliness of those services. Plans with a small enrollment and limited resources often complained that these limitations impeded their ability to implement a more robust language assistance program. Small- and medium-sized plans were encouraged to continue their good work in providing services in accordance with these regulations, and to continue to prioritize and dedicate needed resources to support these important services for the LEP enrollee populations.

PART III: OVERVIEW OF CULTURAL APPROPRIATENESS REPORT

The DMHC created a guideline template for plans to use to file their Cultural Appropriateness Reports in accordance with Section 1367.07. The template was publicly posted to the DMHC Web site in late 2008, and can be viewed on-line at: http://www.dmhc.ca.gov/library/reports/med_survey/car.pdf.

Within one year after a plan's assessment of the linguistic needs of its enrollee population, the plan was required to report to the DMHC the internal policies and procedures it developed to ensure cultural appropriateness. The DMHC has confirmed that all plans have completed and filed their Cultural Appropriateness Reports.

The Cultural Appropriateness Reports addressed the following six areas:

- **Collection of data regarding the enrollee population assessment**
  Plans generally used census data and enrollee surveys for their enrollee population assessments. The enrollees were given surveys in multiple languages to increase the likelihood that the plan would receive responses. One plan reported that the survey provided to its members was translated into seven languages: English, Spanish, Chinese, Korean, Vietnamese, Japanese, and Tagalog.

- **Education of health plan staff who have routine contact with enrollees regarding the diverse needs of the enrollee population**
  Plans generally described robust training programs with ongoing monitoring and regularly scheduled auditing to measure the effectiveness of their training efforts. These mandatory training programs included courses on diversity and cultural sensitivity with the stated goals of achieving cultural competency and eliminating linguistic or cultural barriers to care and service.

- **Recruitment and retention efforts that encourage workforce diversity**
  Plans also reported ongoing recruitment efforts to encourage workplace diversity, including diversity career events, maintaining strong relationships with diversity organizations and media outlets, and integrating diversity messages in recruiting material. One plan reported that it had created a corporate department dedicated to strengthening diversity. Some small plans simply reported equal opportunity policies and compliance.

- **Evaluation of the health plan's programs and services with respect to the plan's enrollee population**
  Complaint monitoring was commonly cited as a valuable indicator or tool in assessing whether a plan is successfully delivering culturally responsive care. Plan monitoring included looking for changes in complaint levels related to cultural and linguistic services and evaluating utilization data for various language assistance services. Where the trends suggested barriers to language assistance services, plans promptly instituted corrective action.

- **The periodic provision of information regarding the ethnic diversity of the plan's enrollee population and any related strategies to plan providers**
  Plans noted that they shared information regarding the ethnic diversity of their enrollee populations with providers through newsletters and Web sites. The types of information shared included summary data on the race and ethnicity of the plan's enrollment population and summary data on the written and spoken language elections of enrollees. Changes to provider manuals were also used to share information with plan providers.

- **The periodic provision of educational information to plan enrollees about the plan's services and programs**
  Enrollee education was accomplished through new member communications, newsletters, and other plan publications that were available in various languages. Plans also reported that posters and signage informing members of the right to request language assistance free of charge are displayed in facilities where enrollees receive care. Some plans reported that their interactive voice response systems offer multilingual prompts in the threshold languages.

RECOMMENDATIONS

As each plan's language assistance program continues to mature, the DMHC notes that the plans are eager to demonstrate the accomplishments of their programs, and their continual willingness to improve language assistance services as needed. With the exception of the resource challenges faced by all health plans in delivering high quality care and language assistance services to their enrollees, the DMHC has had positive experiences in working with health plans in implementing their programs, and in monitoring their compliance with the regulations. The DMHC expects to see continued growth of each plan's language assistance operations, and, as of this report, the DMHC has no recommendations for legislative or regulatory changes.

CONCLUSION

Throughout the development of the language assistance regulations, the DMHC maintained extensive communication and coordination with consumers, health plans, and provider stakeholders to ensure that consumer concerns were considered and health plans' efforts for implementing the requirements were a priority. Although this collaborative process required significant resources, the DMHC believes that these efforts continue to generate growing awareness of the importance of ensuring that all enrollees have the ability to: (1) communicate and understand the information exchanged between them and their health care providers, (2) understand their treatment plans and the options available to them, and (3) engage in the process to maintain optimal health within their health care network.

Through the regulatory authority granted by the Knox-Keene Act, the DMHC will continue to monitor the language assistance programs of all of its licensed health plans. As the Help Center continues to address consumer inquiries and complaints concerning language assistance services, it will also carefully track all issues to ensure that any systemic barriers are promptly removed. DMHC oversight and assessment of the effectiveness of the plans' implementation of their Language assistance programs is ongoing. The DMHC is confident that its licensed plans will continue to refine and improve their programs to ensure the provision of quality language services to their enrollees.

[1] Section 1380(c) requires that surveys performed pursuant to this section shall be conducted as often as deemed necessary by the director to assure the protection of the subscribers and enrollees, but not less frequently than once every three years.

[2] Senate Bill No. 853 (Stats. 2003, ch. 713), hereafter SB 853.

[3] Title 28 of the California Code of Regulations as Section 1300.67.04 (Rule 1300.67.04).

[4] Section 1367.07.

[5] All references to "Section" are to the Health and Safety Code, and all references to "Rule" are to Title 28 of the California Code of Regulations.

[6] California Code of Regulations, title 28, section 1300.67.04 (Rule 1300.67.04), subd. (e)(1).

[7] *Id.*, subd. (e)(2).

[8] *Id.*, subd. (e)(3).

[9] Health and Safety Code section 1367.07.

[10] *Id,*, subd, (b)(3).

[11] Rule 1300.67.04, subd. (c)(1).

[12] Section 1367.04(b)(1)(A)(i-iii) Requirements for translation of vital documents based on the size of the plan's enrollment and results of language needs assessment.

[13] Section 1367.04(b)(1)(A).

[14] Section 1367.04(b)(1)(A)(iii) -- A health care service plan with an enrollment of fewer than 300,000 shall translate vital documents into a language other than English when 3,000 or more or five percent of the enrollee population, whichever number is less, . . . separately indicates in the needs assessment a preference for written materials in that language.

[15] Rule 1300.67.04, subd. (c)(1)(A).

[16] Rule 1300.67.04, subd. (c)(1)(B) and (C).

[17] Health and Safety Code section 1367.04(b)(3).

[18] Rule 1300.67.04, subd. (c)(2).

[19] Rule 1300.67.04, subd. (c)(2)(F)(ii).

[20] *Id.*, subd. (b)(7).

[21] Section 1367.04(b)(1)(C)(ii).

[22] Rule 1300.67.04, subd. (c)(2)(A) and (c)(2)(G).

[23] *Id.*, subd. (c)(2)(G)(ii) -- Stating that the plan must provide LEP enrollees with interpretation services for information contained in plan-produced documents.

[24] *Id.*, subd. (c)(2)(G).

[25] Rule 1300.67.04, subd. (c)(2)(G)(vi).

[26] *Id.*, subd. (c)(2)(G)(vi)(aa)-(ee).

[27] Rule 1300.67.04, subd. (c)(2)(G)(iii).

[28] Rule 1300.67.04., subd. (c)(2)(C)(ii) and (iii).

[29] The Sample Notice of Language Assistance as translated in the specified languages can be found on the DMHC's website: http://www.dmhc.ca.gov/healthplans/gen/gen_langassist.aspx.

[30] The language assistance notice requirements enacted in the DMHC's regulations are slightly different than the comparable notice requirements found in the Insurance Code enacted by the CDI. Under section 2538.3 of title 10 of the California Code of Regulations, CDI health insurance plans are *required* to print notices in 14 languages, including English. In addition, CDI health insurance plans *must* use one of two CDI-developed written notices. The notice that must be used for the health plan's identified threshold languages, and must be translated to the appropriate threshold language is:

> **No Cost Language Services.** You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or XXX-XXX-XXXX. For more help, call the CA Dept. of Insurance at 1-800-927-4357.

For the convenience of the health plans, the DOI provided plans with a translation of this notice in Spanish, Chinese, Vietnamese, Tagalog, and Korean. For the English and the remaining non-threshold languages the following written notice must be provided (in those languages):

> **No Cost Language Services.** You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or XXX-XXX-XXXX. For more help call the CA Dept. of Insurance at 1-800-927-4357.

To support compliance and to assist health plans, the CDI provided plans with a translation of this notice in Spanish, Chinese, Vietnamese, Tagalog, Korean, Armenian, Russian, Japanese, Persian, Punjabi, Khmer, Arabic, and Hmong.

[31] Rule 1300.67.04, subd. (c)(2)(H).

[32] *Id.*, subd. (c)(2)(H)(i)-(iii).

[33] Rule 1300.67.04(c)(2)(G)(v).

[34] The DMHC's recently enacted timely access to care regulations cross reference the language assistance regulations for coordinating interpreter services, with scheduled appointments for health care services, "in a manner that ensures the provision of interpreter services at the time of the appointment."

[35] Rule 1300.67.04(d)(9)(A)

[36] *Id.*, subd. (d)(9)(B).

[37] *Id.*, subd. (d)(9)(C).

[38] Rule 1300.67.04, subd. (c)(3).

[39] *Id.*, subd. (c)(3)(A)-(D).

[40] Rule 1300.67.04, subd. (c)(4).

[41] Rule 1300.67.04, subd. (a)(2).

[42] *Id.*, subd. (a)(2)(A)-(C) and (a)(3).

[43] A deficiency is an area within a health care service plan's operation found to be non-compliant with a specific statute or regulation of the Knox-Keene Act.

[44] The DMHC offers advice and assistance to the plan as deemed appropriate to support the plan's continued compliance with the Act.

[45] Rule 1300.67.04, subd. (c)(1).

[46] Rule 1300.67.04, subd. (c)(2).

[47] Rule 1300.67.04, subd. (c)(3).

[48] Rule 1300.67.04, subd. (c)(4).

[49] See Section 1367.04(b)(1)(B).