Health Plan Compliance with Language Assistance Requirements

Third Biennial Report to the Legislature

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DEPARTMENT OF Managed Health Care

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EXECUTIVE SUMMARY

The Department of Managed Health Care (DMHC) is required by statute to report biennially to the Legislature regarding health plan compliance with the language assistance regulation. This report covers the period of January 1, 2011 through December 31, 2012.

Under the language assistance regulation, California health plans are required to provide language assistance services, including translation and interpretation services, to limited-English-proficient (LEP) enrollees. The regulation became effective on January 1, 2009. The DMHC Division of Plan Surveys monitors compliance with the regulation in its routine medical survey process, which takes place at least every three years for each health plan. In addition, the DMHC tracks complaints filed with its Help center to identify trends in compliance with the regulation.

The DMHC completed 38 routine medical surveys during the reporting period. While deficiencies were cited, those deficiencies were corrected and to date there have been no serious concerns identified through medical surveys. Likewise, there have been few complaints to the DMHC Help Center. One action by the DMHC Office of Enforcement resulted in a $2,500 fine for failing to translate a vital document. Overall, the DMHC has not noted any trend toward non-compliance with the regulation.

INTRODUCTION

In 2003, the California Legislature passed Senate Bill 853, codified at Health and Safety Code section 1367.04, to improve health care access for non-English-speaking and LEP individuals enrolled in health plans. Pursuant to this legislation, the DMHC developed Rule 1300.67.04, which required health plans to:

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

The DMHC is required to provide biennial reports to the Legislature on health plan compliance with the standards under the regulation. The information in this report was gathered through medical surveys conducted by the DMHC Division of Plan Surveys and though the aggregation and analysis of consumer complaints submitted to the DMHC Help Center.

While the DMHC has found few serious deficiencies in health plan language assistance programs, there is an ongoing need to educate enrollees and providers about the requirements regarding the availability of free and easily accessible language assistance services.

PART I: LANGUAGE ASSISTANCE REGULATION REQUIREMENTS

The language assistance regulation requires:

Enrollee Assessment

Determination of Threshold Languages through Population Analysis

Recognizing that health plans often serve different and diverse communities, Health & Safety Code section 1367.04[1] provides health plans with an ability to tailor language assistance services to each plan's enrollee population. Each health plan is required to complete an assessment every three years of the linguistic needs of their enrollee population. Under the regulations, based on the plan's size and language needs assessment, the plan determines its "threshold languages". 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 1 summarizes the criteria for determining a plan's threshold language(s).

Table 1: Threshold Language Criteria

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	0 languages	5.0%	3,000

Each plan's initial assessment is required to be based on statistically valid population analysis methods, and plans are required to collect and record enrollees' language data using reasonable survey methods. 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.

[1] All references to "Section" are to the Health and Safety Code unless otherwise indicated.

Language Assistance Services

The language assistance regulations require health plans to develop extensive policies and procedures, including specified sections, describing how they will provide effective language assistance services at all points of contact where language assistance may be reasonably anticipated.

Assessment of Services

Health plans are required to assess and describe all points of contact where the need for language assistance might reasonably arise. In addition, plans are required to independently assess and describe the resources necessary to provide those services to enrollees, and to describe the steps they 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," 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.
- Explanation(s) 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.

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 if the enrollee

needs assistance to understand the non-standardized document. If the enrollee requests translation, the translated document must be provided to the enrollee within 21 days. 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. 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. 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.

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. The regulation provides examples of some of the services that may be provided by the plan including:

- 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.

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.

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 plans' 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.

To assist the health plans in meeting the language assistance notice requirements, the DMHC developed the following sample notice of the availability of language assistance:

> **"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 HMO 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.

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

Quality of Services

Proficiency Standards

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

Plans must both 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. At a minimum, a plan's language assistance 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.[2]

[2] 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.

Access to Qualified Interpreters

Plans must have policies and procedures for providing enrollees with qualified interpreters 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 shall 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. 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.

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 their fluency in languages other than English.
- The plan requires all contracting providers to provide quarterly updates regarding any changes in the language capabilities of currently employed providers.
- The plan's quality assurance audits of contracting providers confirm and document the accuracy of provider language capability disclosure forms and attestations.

Staff Training

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

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.

Medi-Cal Deeming

Health plans that participate in California's Medi-Cal program were required to provide language assistance services prior to enactment of Senate Bill 853. The Medi-Cal requirements generally meet or exceed the Knox-Keene Act enactment of standards for language assistance. In recognition of this, the regulations allow the DMHC to deem health plans that comply with the Medi-Cal language assistance requirements to be compliant with the Knox-Keene Act language assistance requirements, 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 Knox-Keene Act regulations.
- The plan applies the Medi-Cal standards for language assistance to the plan's non-Medi-Cal lines of business.

PART II: PLAN COMPLIANCE WITH STANDARDS

Overview of the DMHC Division of Plan Surveys

The DMHC Division of Plan Surveys conducts compliance audits (routine onsite medial surveys) of licensed health plans at least once every three years. Beginning in January 2009, the DMHC incorporated a review of each health plan's language assistance program into the routine medical survey.

Since all plans are required to comply with the language assistance regulations, all 38 surveys conducted in 2011 and 2012 assessed plan compliance. The size and type of the health plans vary from more than one million commercial enrollees to plans with enrollment smaller than 10,000 commercial enrollees. The DMHC surveyed full service plans as well as specialized plans offering vision, dental, behavioral health, or chiropractic services (see Table 2).

Table 2: Number of Surveys Completed by Year

Health Plan Type	2011	2012
Full Service	1	11
Dental	6	5
Behavioral Health	2	3
Vision	6	1
Chiropractic	1	2
Total	**16**	**22**

During the report period of January 1, 2011 to December 31, 2012, the DMHC completed 38 routine medical surveys. The DMHC found a total of 25 deficiencies in the plans' language assistance programs.

Survey Results: Plan Type

Specialized health plans, such as dental plans, had the largest number of deficiencies. This is a trend that continues from the second biennial report. The DMHC has found, in general, these deficiencies result from specialized plans having smaller enrollment and therefore, fewer resources to provide language assistance services.

Table 3 identifies the number of deficiencies by health plan type.

- Nearly half (48%) of the deficiencies in language assistance programs occurred in dental plans during the 2 year survey period.
- Twenty eight percent (28%) of the deficiencies were attributed to vision plans.
- Very few full service plans had deficiencies in their language assistance programs, and those that had deficiencies had enrollments of less than 150,000.

Table 3: Deficiencies by Health Plan Type

Health Plan Type	Deficiencies	Number of Plans with Deficiencies
Full Service	3	2
Dental	12	5
Behavioral Health	3	4
Vision	7	5
Chiropractic	0	0
Total	**25**	**16**

Table 4 identifies the number of deficiencies based on the size of the plans' commercial enrollment. This illustrates the disproportionately high number of language assistance deficiencies in plans with fewer than 150,000 enrollees (64%). The majority of plans in the "small" category are dental and vision plans.

Table 4: Survey Deficiencies by Health Plan Enrollment

Health Plan Enrollment	Deficiencies
Large (≤ 500,000)	6
Medium (150,000 to 499,999)	3
Small (≥ 150,000)	16
Total	**25**

Table 5 lists the health plans surveyed in 2011 and 2012.

Table 5: Health Plans Surveyed

2011 Surveys	2012 Surveys
Full Service Plans	***Full Service Plans***
Sistemas Medicos	Aetna Health of California
Specialized Plans	Association Health Care Management
Dental	Blue Shield of California
American Healthguard Corporation	Cigna Healthcare
Dedicated Dental Systems, Inc.	Heritage Provider Network
Delta Dental of California	Kaiser Foundation Health Plan
Dental Health Services	Primecare Medical Network
Jaimini Health, Inc.	Sharp Health Plan
Liberty Dental Plan of California	United Health Care of California
Behavioral Health	Ventura County Health Care Plan
Avante Behavioral Health, Inc.	Western Health Advantage
ValueOptions of California, Inc.	***Specialized Plans***
Vision	**Dental**
EYEXAM of California, Inc.	California Dental Network
Golden West Health Plan, Inc.	Consumer Health
March Vision Care, Inc.	Dental Benefit Providers of California
Safeguard Health Plans, Inc.	Managed Dental Care
Vision First Eye Care, Inc.	Western Dental Services, Inc.
Vision Service Plan	**Behavioral Health**
Chiropractic	Managed Health Network
American Specialty Health Plans, Inc.	Magellan Health Services of California
	US Behavioral Health
	Vision
	Max Vision Care, Inc.
	Chiropractic
	ACN Group of California, Inc.
	Landmark Healthplan of California, Inc.

Survey Results: Language Assistance Program Standards

Table 6 identifies the deficiencies relating to the five primary language assistance program elements: 1) Implementation; 2) Standards for Enrollee Assessment; 3) Standards for Staff Training; 4) Standards for Language Assistance Services; and 5) Standards for Compliance Monitoring.

With 13 deficiencies, the area of standards for compliance monitoring accounts for about half of all deficiencies cited. All but 2 of the deficiencies in compliance monitoring occurred in specialized plans. The 3 most common oversight issues were:

- Lack of adequate monitoring of the accuracy of provider capability disclosure forms and attestations.
- Lack of adequate proficiency by internal staff providing interpretation services provided to plan enrollees.
- Not ensuring contracted bilingual providers and/or provider office staff are trained and competent to provide interpretation services.

Table 6: Survey Deficiencies by Language Standard

Language Standard	Deficiencies
Implementation	3
Standards for Enrollee Assessment	8
Standards for Staff Training	0
Standards for Language Assistance Services	1
Standards for Compliance Monitoring	13
Total	**25**

When a deficiency is identified, the plan is required to submit a corrective action plan within 30 days describing the action taken to correct the deficiency and the results of such action. The department then monitors the plan's activities to ensure implementation of the activities to achieve compliance. Any remaining uncorrected deficiencies and deficiencies that were corrected (including a description of the plan's corrective action) are identified in the final public report. Frequently, deficiencies that remain uncorrected, remain so because of the time required to ensure sustained implementation of correction. The department then conducts a follow-up review of the plan no later than 18 months following release of the final report. If the plan has not demonstrated compliance by the conclusion of the follow up period, the department may take additional enforcement actions such as issuing fines, penalties, injunctions, cease and

desist orders, or other administrative penalties or actions depending on the facts surrounding the deficiency. The DMHC completed 38 routine medical surveys during the reporting period. While deficiencies were cited, those deficiencies were corrected and to date there have been no serious concerns identified through medical surveys.

Enrollee Inquiries Related to Language Assistance Services

The DMHC Help Center provides information to consumers on accessing language assistance services through their health plans and facilitates communication between the consumer and health plan to promptly arrange language services when needed.

Table 7 provides a 24-month summary of the number of inquiries received by the Help Center related to language assistance. The most common inquiry is a consumer requesting information on the specific provisions of the language assistance laws, followed by inquiries regarding how to obtain an interpreter and/or translated documents. Overall, the number of inquiries dropped by 65 percent from the prior two-year period.

Table 7: Language Assistance Inquires

Type of Issue	Number of Inquiries 2009-2010	Number of Inquiries 2011-2012	Total	Percentage of Total Language Assistance Inquiries 2009-2012
Consumer – Inquiry about how to obtain translated documents	31	6	37	18.1%
Consumer – Inquiry about how to obtain an interpreter	26	18	44	21.6%
Consumer – Inquiry about the language assistance laws	39	8	47	23%
Consumer – Requested interpreter, but none was provided	9	5	14	6.9%
Consumer - Requesting a provider that speaks their language	0	12	12	5.9%
Provider – Unsure how to access a plan's language assistance program	7	1	9	4.4%
Provider – Inquiry about the language assistance laws	19	2	21	10.3%
General – Inquiry about how to become employed as an interpreter	20	1	21	10.3%
Total Calls Regarding Language Assistance	**151**	**53**	**204**	**100%**

Enrollee Complaints Related to Language Assistance Services

The Help Center reviews and resolves enrollee complaints submitted to the DMHC to ascertain a plan's compliance with the Knox-Keene Act. Complaints related to obtaining language assistance services comprise less than .01% of all inquiries and complaints received in the 2 years covered by this report. Over 2 years, the Help Center received 12 complaints regarding language assistance services. All were regarding obtaining translation or interpretation services.

CONCLUSION

During this two-year report period, DMHC noted no serious concerns with health plans' language assistance programs overall. However, specialized plans, particularly dental and vision plans with small enrollments, accounted for the majority of deficiencies cited. These small plans lack adequate systems to monitor compliance with language assistance requirements regarding the language proficiency of provider and plan staff, and training to provide interpretation services. While deficiencies were cited, those deficiencies were corrected and to date there have been no serious concerns identified through medical surveys.

While the DMHC Help Center received few consumer complaints regarding language assistance, the Help Center will continue to investigate and resolve consumer issues related to language access, and if any systemic barriers to language assistance services are identified, the DMHC will act promptly to remove them.

The DMHC will continue its ongoing oversight and assessment of the effectiveness of the plans' language assistance programs. The DMHC also will work with its contracted community-based organization partners to conduct outreach regarding consumers' rights to access language assistance and the availability of the Help Center to assist individuals with language access problems.