POLICY BRIEF

March 2006

Holding Health Plans Accountable

The Provision of Culturally and Linguistically Competent Services by Health Plans Participating in the Healthy Families Program

CPEHN
California Pan-Ethnic Health Network

Asian Pacific American Legal Center of Southern California
The Health Consumer Alliance
LCHC Latino Coalition for a Healthy California
APIAHF Asian & Pacific Islander American Health Forum
CPCA California Primary Care Association
NHeLP National Health Law Program

California Pan-Ethnic Health Network (CPEHN)

CPEHN was established in 1992 and incorporated as a 501c(3) nonprofit organization in 1998 in response to the need for a representative community-driven and community-driven voice in health policy. Our mission is to improve access to health care and eliminate health disparities by advocating for public policies and sufficient resources to address the health needs of communities of color.

Project Partners:

Asian and Pacific Islander American Health Forum

Asian Pacific American Legal Center

California Primary Care Association

Fresno Health Consumer Center

Latino Coalition for a Healthy California

National Health Law Program

Holding Health Plans Accountable

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Introduction

The Healthy Families Program provides health insurance coverage to over 732,000 Californians. The program is vital to the health of our communities. Nearly three out of four enrollees are people of color[1]. Ensuring quality care is provided to everyone enrolled in the program must be a priority.

The community needs greater assurances that health plans are providing culturally and linguistically appropriate services to enrollees in the Healthy Families Program. This is the finding based on a review of the state's current process of overseeing health plan compliance with the Healthy Families Program's cultural and language access requirements.

1 Managed Medical Insurance Board enrollment reports.

CPEHN and our partners in the Language Access Advocacy Project (LAAP), which is funded by The California Endowment, conducted the review. Our LAAP partners include the Asian and Pacific Islander American Health Forum, Asian Pacific American Legal Center, California Primary Care Association, Fresno Health Consumer Center, Latino Coalition for a Health California, and National Health Law Program.

Quality health care for all cannot be achieved unless the state fully enforces legal requirements for cultural and linguistic access.

Background

CPEHN works with administrative agencies to ensure that the health needs of all Californians are met, regardless of our race, ethnicity, primary language, or cultural background. Our ***Multicultural Principles for a Healthy California*** states that quality health care for all cannot be achieved unless the state fully enforces legal requirements for cultural and linguistic access. The state needs to do more to realize this goal.

As a result of prior advocacy work by CPEHN and other LAAP partners, the Healthy Families program contains detailed requirements for cultural and linguistic access. The requirements exist as provisions in the contracts between participating health plans and the state agency that administers the program, the Managed Risk Medical Insurance Board (MRMIB). Although MRMIB is committed to ensuring equal access to the program, CPEHN and the LAAP partners have concluded that MRMIB's oversight of health plan compliance with the requirements needs improvement.

Under the terms of their contracts with the state, health plans participating in Healthy Families fill out an annual questionnaire detailing their cultural and linguistic services. MRMIB then produces a summary of the health plan reports, which can be found at http://www.mrmib.ca.gov/MRMIB/HFP/Final03C&LRptSum.pdf. These reports are the only mechanism for gauging health plan compliance with the requirements.

CPEHN and our LAAP partners issued a public records request to obtain 28 health plan reports submitted to MRMIB for the period of July 1, 2003 to June 30, 2004. Prior to our request, the reports were not shared with the community. We analyzed the individual health plan reports as well as the summary by MRMIB.

Findings

Our overall finding is that the community does not have enough information to be certain that everyone in the Healthy Families Program has access to cultural and linguistic services as required under the program.

In order to appropriately evaluate health plan practices, health plans' reports to MRMIB should include substantial detail on how the plans comply with each cultural and linguistic access requirement. MRMIB should then provide a summary report to the community that describes and evaluates individual health plan's compliance with the requirements. MRMIB should also verify the accuracy of the information reported by each plan.

Currently, health plans and MRMIB do not follow these practices. The health plan reports and the MRMIB summary do not provide enough information to determine the extent to which health plans are complying with requirements, and MRMIB does not confirm the validity of the information reported by health plans.

We found that health plans often did not answer all the questions asked of them in the questionnaire or answered them inappropriately.

Health plans did not always answer all of the questions, and did not provide enough detailed information on their compliance with requirements.

We found that health plans often did not answer all the questions asked of them in the questionnaire or answered them inappropriately. For example, Kaiser Permanente's report did not follow the requested format and left questions unanswered. This is unfortunate because we know Kaiser Permanente has many promising practices to share that would benefit other health plans. Inland Empire Health Plan also did not follow the format appropriately.

There were also instances in which it was clear that more detailed information in the health plan's responses would have helped MRMIB and the public to evaluate each plan's services. Some examples include:

- Blue Shield of California reports that it provides enrollees with "Language Preference Response Cards." This may be a promising practice, but unfortunately Blue Shield does not provide enough information for us to assess this component of their program.

- Health Net reports that they provide 24-hour access to its member services center. While 24-hour access is vital, the plan is not clear about how they provide interpretation services for the center.
- San Francisco Health Plan's report states that it makes the provision of face-to-face interpretation services the responsibility of plan providers. However, the Healthy Families' requirements put ultimate responsibility for compliance on health plans. From the report, it is not clear how SFHP ensures that all their enrollees have access to interpretation services. The LAAP partners also believe that the provision of language services is a shared responsibility of plans and providers, though the Healthy Families Program contracts ultimately place the responsibility on health plans to ensure that the services are provided.
- Access Dental's report is not clear on how it evaluates the bilingual skills of staff.
- Community Health Group reports it conducts audits of provider sites to confirm ongoing threshold language capabilities on a 'regular' basis but do not define how often these audits occur.

By not identifying the activities of each health plan by name, the summary fails to hold health plans accountable.

The MRMIB summary report hides the names of plans.

The MRMIB summary report allows health plans to hide from public scrutiny. The summary does not mention any health plan by name; it only provides a general list of the strategies plans are utilizing to provide cultural and linguistic services. By failing to identify the activities of ***each*** health plan by name, the summary fails to hold health plans accountable. It also masks the originators of promising practices. Our review of the individual health plan reports shows that some plans are utilizing innovative approaches to meet their obligations.Heralding their achievements can help motivate other plans to improve their own services. For example:

- In the report from Care 1st, we learn that its nurses conduct audits of medical charts to ensure that providers are recording members' primary language.
- CalOptima reports that it maintains an information system capable of identifying the member's language, documenting his/her cultural

needs, and identifying any complaint made related to cultural and linguistic issues. CalOptima also reports that it plans to monitor and track the ratio of members to providers speaking the same language every 18 to 24 months. This could help ensure a diverse provider network capable of meeting member language and cultural needs.

- Ventura County Health Plan and Kern Family Health Care conduct 'mock calls' to providers' offices to test language services.

MRMIB should better use the information provided to ensure compliance.

It is not clear how MRMIB uses the reported information to ensure health plans are complying with requirements or to follow-up with plans that need to take corrective actions. For instance, VSP reports that they provide interpretation services only during business hours. It is our understanding that plans, even dental plans, are required to provide 24-hour access to interpretation. In addition, Care 1st left blank a question on how they document requests for, or refusals of, interpreter services. It is not clear if this was an oversight or if they have no mechanism for compliance with this requirement. The MRMIB summary report makes no mention of these problems or what actions MRMIB took to ensure that these health plans were indeed complying with the requirements.

MRMIB does not conduct audits of health plans.

Finally and most importantly, MRMIB has no means of ensuring that the health plans' reported information is accurate. Unlike the Department of Managed Health Care (DMHC) or the Department of Health Services (DHS), MRMIB does not conduct audits of or sites visits to health plans to ensure that they are doing what they say they are doing, or that they are meeting the program requirements.

Recommendations and Next Steps

The community demands that government agencies collect and verify information from health plans to ensure they are fulfilling their obligation to provide services that address the health needs of our diverse communities. We believe that by slightly amending the reporting process, MRMIB can receive better information from health plans and report that information

more effectively to the community. More importantly, we also believe that health plans need to be audited for compliance with cultural and linguistic requirements and that MRMIB can most efficiently accomplish this by collaborating with another state agency that already audits health plans, such as the Department of Managed Health Care (DMHC).

Audit health plans in conjunction with DMHC.

MRMIB does not conduct audits of the health plans that participate in their program. However, DMHC audits all health plans licensed in the state for compliance with several laws and regulations. Although DMHC does not currently audit plans for compliance with any cultural competency or language access issues, they will soon begin to do so.

Health plans need to be audited for compliance with cultural and linguistic requirements.

SB 853 (Escutia), a bill sponsored by CPEHN and signed into law in 2003, comes into effect in 2006. The new law requires all health plans (whether they participate in Healthy Families or not) to provide language access services. Therefore, beginning this year, all health plans will be responsible for providing some degree of language access, including providing each Limited English Proficient enrollee with an interpreter. Eventually, DMHC will be auditing plans for compliance with these new requirements.

The new cultural and language access requirements that are called for under SB 853 are still being developed by DMHC. CPEHN and our partners are advocating for these requirements to be strong and effective, but it is likely that they will differ from the Healthy Families contract requirements, and perhaps not provide as many guarantees for cultural and linguistic access. Therefore, the new audits DMHC will conduct to enforce SB 853 ***cannot*** be substituted for audits done specifically to ensure compliance with the Healthy Families Program requirements. However, MRMIB could take advantage of the new DMHC auditing process by requesting that DMHC look for health plan compliance with the Healthy Families cultural and linguistic requirements, and by reviewing DMHC's findings.

DMHC and MRMIB should collaborate so that when health plans are audited for compliance with SB 853, participating plans are simultaneously audited for compliance with the Healthy Families cultural and linguistic standards. Joint audits between government agencies are a standard

practice. DMHC and DHS jointly audit health plans for compliance with similar or overlapping requirements. Such collaboration will allow MRMIB to ensure their requirements are being met without unduly burdening health plans because plans would already be undergoing a DMHC audit for language services. For plans that have Healthy Families and Medi-Cal Managed care programs, MRMIB, DHS, and DMHC should all collaborate in conducting the audits. By collaborating, government agencies can ensure that health plan enrollees and participants in the Healthy Families Program are receiving all the services entitled to them.

Require health plans to fill out reports appropriately and with more detail.

Health plans should continue to submit annual reports to MRMIB on their cultural and linguistic services. However, health plans must take more care to appropriately answer all the questions asked of them, in the manner specified, and MRMIB staff should follow-up with health plans that do not provide all the requested information in the correct format. MRMIB should insist that more detailed responses be provided by health plans. MRMIB should also review the questionnaire to ensure the questions are focused and clearly track all of the requirements.

Identify plans by name in the MRMIB summary report.

A summary report should continue to be produced by MRMIB. The MRMIB summary report must include information on what each individual participating health plan is doing to meet its obligations, including which plans are not meeting all the contract requirements and which are developing promising practices. This is the only way the community can hold specific health plans accountable.

Due to the advocacy efforts of CPEHN and our partners in 2004, we won improvements to the contracts between health plans and MRMIB. These include, among other things, a clarification that the health plans' reports are subject to public review. Therefore, there is no impediment to MRMIB presenting information from each plan to the public in an easy-to-read format.

Conclusion

CPEHN and our partners will continue to advocate for the adoption of administrative changes to improve government oversight of our health system. We look forward to working with MRMIB and DMHC staff on the implementation of our recommendations.

We will assist DMHC in conducting its new audits and will help MRMIB develop improved ways of providing important information on health plan compliance to the public. We will also increase public awareness of cultural and linguistic rights and requirements, and work with health plans to improve their practices.

In fact, in 2006, CPEHN will be hosting informational symposia to educate health plan staff on promising ways to improve services for Limited English Proficient enrollees and communities of color. By collaborating with community, health plans, and government we can develop policy solutions that help us all live healthier lives.

For more health policy resources and data or to
support our work, go to
CPEHN's Multicultural Health Web Portal at:

www.cpehn.org

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