White Paper

Are You Speaking My Language?

A Guide for Understanding and Complying with the California Health Care Plan Requirements for Language Interpretation and Translation

Steven M. Weinberg
Weinberg Legal Group, PC

Executive Summary

The California legislature in 2003 amended the Knox-Keene Health Care Services Plan Act of 1975 by enacting SB 853, which mandates that all California health plans have to provide language translation and interpretation services to their enrollees who have limited English proficiency. This legislation was deemed necessary to address the significant and growing language barriers encountered in the health care system by limited English proficient enrollees, defined as "enrollee[s] who [have] an inability or limited ability to speak, read, write, or understand the English language at a level that permits that individual to interact effectively with health care providers or plan employees."[1]

Senate Bill 853 required that the Department of Managed Health Care (DMHC) adopt language assistance program regulations and devise a plan for ensuring health plan providers' compliance with those regulations. These regulations went into effect on February 23, 2007.

The regulations establish two critical deadlines for health care plans. The first requires that by **July 1, 2008**, every health care service plan must file an amendment to its quality assurance program providing its written language assistance program policies and procedures together with information and documents demonstrating compliance with the requirements and standards of the Act. The second deadline requires that by **January 1, 2009**, every plan must have established and implemented a "language assistance program" in compliance with the regulations. After January 1, 2009, every contract between a health care provider and a plan that is issued, amended, delivered or renewed will require compliance with the plan's language assistance program.

As with most legislation of this complexity, assuring compliance is a daunting task.

This White Paper has been developed to assist health care plans affected by the new Act to understand its implications and requirements, and to address the importance of the role of language interpretation and translation companies in establishing and effectively running and managing a "language assistance program."

Introduction

The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care (the "DMHC"). Recently, Senator Martha Escutia and her staff discovered a series of statistics and data showing that millions of California residents were not receiving, or seeking, the kind of health care services contemplated by Knox-Keene. Statistics, including from the 2000 census, showed that as many as 40% of California residents speak a language other than English at home. A survey of health care providers resulted in 70% of those surveyed responding that language barriers interfered with a patient's understanding of treatment advice. A sampling of HMO membership compiled by the UCLA Center for Health Policy Research and sponsored by the Office of the Patient Advocate showed similar results.

[1]DMHC Regulations, Title 28, Division 1, Chapter 2, Article 7, California Code of Regulations Section 1300.67.04: Language Assisted Programs (hereinafter, the "DMHC Regulations"), subsection (b)(3).

The evident barriers to health care for limited English proficient health care plan enrollees resulted in the introduction of Senate Bill 853. As was stated by Ellen Wu, MPH, Executive Director of the California Pan-Ethnic Health Network, one of the bill's sponsors, "Barriers to health care happen to people of color every day, such as going to the doctor or to fill a prescription, only to find that no one speaks your language…[this bill] change[s] the rules in California so that our family and friends can understand their doctor and health plan information. Because of these new requirements, a health plan will be accountable for providing quality services to its diverse members. This program is a model for the rest of the country." A list of plans (as of March 8, 2008) that must comply with SB 853 is available at: http://www.dmhc.ca.gov/library/reports/licensing/licensed.pdf .

Senate Bill 853 was enacted as a new Section 1367.04 to the California Health and Safety Code. This new law required the DMHC to promulgate regulations requiring the 96 full-service and specialty health care plans (e.g., dental and vision) and insurers (hereafter collectively referred to as "health care plans") under the jurisdiction of the DMHC to assess the linguistic needs of its enrollee population and to provide for language translation and interpretation of medical services, and to otherwise develop and implement its own language assistance program. In addition to ensuring timely access to interpreters, health care plans also are charged with providing translation of relevant care-related documents including standard letters and notices of insurance eligibility and membership requirements; notices of any denial, reduction, modification or termination of services and benefits; and notices of the right to file grievances or appeals. These regulations, after a series of public hearings, were issued in February 2008.

The DMHC is responsible for approving the individual language assistance programs and enforcing their adherence. The health care plans' language assistance programs also will be evaluated through the DMHC's HMO Help Center through their regular surveys and programs assessments. Violations by health care plans of their language assistance programs will be referred to the DMHC's enforcement unit for evaluation, which will have the authority to issue fines or penalties.

The new Act and its regulations do not apply to Medi-Cal or Medicare enrollees. If a plan has both Medi-Cal and non-Medi-Cal enrollees, the health care plan's plan will be in compliance with the Act if (a) it already is meeting Medi-Cal standards for providing language assistance services, including the standards for timeliness and proficiency of interpreters,(b) applies these standards to the plan's non-Medi-Cal lines of business, and (c) the DMHC determines that the plan is in compliance with the Medi-Cal standards.

Establishing Language Assistance Programs

The regulations were designed to ensure that the intended recipients of this legislation actually receive its benefits without placing an extraordinary burden on health care plans and insurers. Nonetheless, the burden has been placed on the health care plans to design, implement and effectively manage the "language assistance programs" that are the focal point for this new system.

Every health care plan is now required to adopt a language assistance program that will be documented in written policies and procedures, and will address, at a minimum, the following four elements:

- Standards for enrollee assessment;
- Standards for providing language assistance services;

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- Standards for staff training; and
- Standards for compliance monitoring.

Each of these Standards carries with it specific rules:[2]

1. Standards for Enrollee Assessment.

Every health care plan will have to begin with an assessment of the linguistic needs of its enrollees. Each plan is charged with developing a demographic profile and surveying the linguistic needs of individual enrollees. In assessing its enrollee population, each health care plan at minimum must:

(a) Develop a linguistic needs demographic profile of the plan's enrollee population for the purposes of calculating "threshold languages" (defined in the regulations as "the language(s) identified by a plan pursuant to Section 1367.04(b)(1)(A) of the Act")(see discussion below) and reporting this profile to the DMHC. All plans must apply statistically valid methods for population analysis in developing the demographic profile. Such methods include census data, client utilization data from third parties, data from community agencies and third party enrollment processes.

The "threshold languages" determination is to be made as shown in the following table:

Number of enrollees in Plan	Number of threshold languages[3]	**Number of additional languages[4]**
1,000,000+	Top 2 languages other than English as determined by needs assessment	**Any additional languages as shown to be needed by 0.75% or 15,000 of the enrollee population, whichever is less**
300,000 to 999,999	Top 1 language other than English as determined by needs assessment	**Any additional languages as shown to be needed by 0.1% or 6000 of the enrollee population, whichever is less**
Less than 300,000	**Any language other than English as shown to be needed by 5% or 3000 of the enrollee population, whichever is less**	**N/A**

The threshold languages are to be used both in language interpretation at the places where limited English proficient ("LEP") enrollees are likely to need them (see discussion of "points of contact" below) and in the translation of "vital documents," which are defined in the regulations as "the following documents, when produced by the plan (plan-produced documents) including when the production or distribution is delegated by a plan to a contracting health care service provider or administrative services provider:

(A) Applications;

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

[2]The following is a detailed summary of the Regulations. One must refer to the Regulations themselves for all of the requirements.

[3]These numbers are exclusive of Medi-Cal enrollees. A Plan enrolled in a Healthy Families Program has the option to include or not include enrollees in that Program in determining threshold languages.

[4]Also exclusive of Medi-Cal enrollees and an option for plans in a Healthy Families Program.

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

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

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

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

(G) [certain] enrollee disclosures required by Section 1363(a)(1), (2) and (4) of the Act."[5]

(b) Survey its enrollees in a manner designed to identify the linguistic needs of each enrollee, and record the information in the specific enrollee's file. Plans are given a fair amount of flexibility in administering the survey, and may use existing processes and methods to distribute the survey, including existing enrollment and renewal processes, subscriber newsletters, mailings and other means. Compliance with the foregoing survey requirement may be achieved by a plan's distributing to all subscribers a written document explaining, in English and in the plan's threshold languages, (i) the availability of free language assistance services, and (ii) how to inform the plan and relevant providers of the preferred spoken and written languages of the subscriber and other enrollees under the subscriber's contract, including all individual subscribers under group contracts; and

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

2. Standards for providing language assistance services: Policies and Procedures

Once the demographics of enrollees and the threshold languages have been determined, each plan must develop language assistance program policies and procedures. These need to include the following minimum items, and must be filed with the DMHC by **July 1, 2008** for review and approval, must be complied with as approved, and incorporated into the plan's language assistance program.

(a) All "points of contact" where the need for language assistance may be reasonably anticipated. As defined in the regulations, a "point of contact" is "an instance in which an enrollee accesses the services covered under the plan contract, including administrative and clinical services, and telephonic and in-person contacts."[6]

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

(c) The plan's processes for informing enrollees (i) of the availability of language assistance services at no charge to them, and (ii) how to access language assistance services. The minimum requirements for these processes are those that:

[5] Regulations, subsection (b)(7).

[6] Regulations, supra subsection (b)(4).

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- promote effective identification of LEP language assistance needs at points of contact to ensure that they are informed at the points of contact that interpretation services are available at no cost;
- facilitate individual enrollee access to interpretation services at points of contact;
- provide for the inclusion of the notice required with all "vital documents," all enrollment materials and all correspondence, if any, from the plan confirming a new or renewed enrollment. However, if documents are distributed in an LEP enrollee's preferred written language the notice need not be included;
- provide for the inclusion of statements in English and in the threshold languages in or with brochures, newsletters, marketing materials and other materials that are routinely disseminated to the plan's enrollees, that advise enrollees of the availability of free language assistance services and about how to access them

(d) Processes to ensure that LEP enrollees receive information regarding their rights to file a grievance and seek an independent medical review in threshold languages and through oral interpretation. All plans have to ensure that grievance forms and procedures in threshold languages are made readily available to enrollees and to contracting providers for distribution to enrollees upon request.

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

(f) Processes and standards for providing translation services, including:

- A list of the threshold languages identified by the plan;
- A list of the types of standardized and enrollee-specific vital documents that must be translated and the applicable standards for making translated vital documents available to subscribers and enrollees;[7]
- A description of how the plan will provide or arrange for the provision of translation of vital documents at no charge to enrollees;
- A requirement that non-English translations of vital documents must meet the same standards required for English language versions of those documents; and
- A requirement that for vital documents that are not standardized, but which contain enrollee-specific information, the English version together with the DMHC-approved written notice of the availability of interpretation and translation services will be provided, and, if a translation is requested, the plan will provide the requested translation.

[7]Plans need not translate subscriber contracts, evidences of coverage and other large disclosure forms and enrollee handbooks in their entirety, but may excerpt from large documents in a format that permits cost-effective and timely production and distribution, so long as there is no loss of accuracy or meaning by doing so. A plan may demonstrate compliance regarding translation of the disclosures specified at subsection (b)(7)(G) if the plan provides a standardized matrix that lists the major categories of health care services covered under the plan's subscriber contracts, together with the corresponding co-payments and coinsurance, and exclusions and limitations, and disclosing any applicable deductibles and lifetime maximums, using the same sequence as the uniform matrix described at Section 1363(b)(1) of the Act.

(g) Processes and standards for providing individual enrollee access to interpretation services at points of contact at no charge, including:

- A list of the non-English languages likely to be encountered among the plan's enrollees.
- A requirement that the plan shall provide LEP enrollees with interpretation services for information contained in plan-produced documents.
- A requirement that qualified interpretation services will be offered to LEP enrollees, at no cost to the enrollee, at all points of contact, including when an enrollee is accompanied by a family member or friend who can provide interpretation services.
- A description of the arrangements the plan will make to provide or arrange for the providing of timely interpretation services at no charge to LEP enrollees at all points of contact where language assistance is needed. "Timely" means in a manner appropriate for the situation in which language assistance is needed.[8]
- The range of interpretation services that will be provided to LEP enrollees as appropriate for the particular point of contact. The range of services may include, but is not limited to:
  - Arranging for the availability of bilingual plan or provider staff who are trained and competent in the skill of interpreting;
  - Hiring staff interpreters who are trained and competent in the skill of interpreting;[9]
  - Contracting with an outside interpreter service for trained and competent interpreters;
  - Arranging formally for the services of voluntary community interpreters;
  - Contracting for telephone, videoconferencing or other telecommunications supported language interpretation services.

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

- A documented and demonstrated proficiency in both English and the other language(s);
- A fundamental knowledge in the languages of health care terminology and concepts relevant to health care delivery systems; and
- Education and training in interpreting ethics, conduct and confidentiality.[10]

[8]Interpretation services are not timely if delay results in the effective denial of the service, benefit, or right at issue. A plan's language assistance program has to specify quality assurance standards for timely delivery of language assistance services for emergency, urgent and routine health care services, and shall include standards for coordinating interpretation services with appointment scheduling.

[9]The phrases "trained and competent in the skill of interpreting," "qualified interpretation services" and "qualified interpreter" mean that the interpreter meets the plan's proficiency standards described in Regulations subsection (c)(2)((H).

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

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3. Standards for staff training

Every health care plan is charged with implementing a system to provide adequate training about the plan's language assistance program to all plan staff that have "routine contact" with LEP enrollees. The training must include instruction on:

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

4. Standards for compliance monitoring

As part of the burden on health care plans, each plan must monitor its language assistance program, including delegated programs, and make modifications as necessary to ensure compliance with the Act and regulations.

DMHC Review of Language Assistance Programs

Once submitted, the DMHC will review each plan's proposed language assistance program, and will evaluate the totality of the plan's program to determine whether the program as a whole provides meaningful access for LEP enrollees. In making this evaluation, the DMHC may consider a variety of relevant operational and demographic factors, including:

- Whether the plan is a full service plan or specialized health care service plan;
- The nature of the points of contact;
- The frequency with which particular languages are encountered;
- The type of provider network and methods of health care service delivery;
- The variations and character of a plan's service area;
- The availability of translation and interpretation services and professionals;
- The variations in cost of language assistance services and the impact on affordability of health care coverage; and
- A plan's implementation of best practices and utilization of existing and emerging technologies to increase access to language assistance services, such as video interpreting programs, language translation software, collaborating with other plans to share a pool of interpreters, and other methods and technologies.

The Implications of this Law

For the first time in their history, California health care plans are responsible for the language interpretation and translation needs of their enrollees, a population of millions. The Act is viewed as a model for other states and for the future, which means that the DMHC actively will monitor and review the language assistance plans to ensure compliance, and report to the legislature, as the Act requires.

The fulfillment of the Act's intent only will come into existence if the interpreters and translators involved have been adequately trained and are effective in their roles. There is too much a stake if they are not; the intended beneficiaries of the Act will not be benefited, health care plans will be forced to spend funds and devote administrative time to ensure that proper interpretation and translation is occurring, and confidentiality of information covered by HIPAA and other privacy laws could be compromised.

For these and other reasons it is critical that health care plans choose a language interpretation/translation service that can ensure the high level of reliability, training and effectiveness required for the Act's purpose to be fulfilled and providing millions of LEP plan enrollees the opportunity to have access to the same level of care as their English speaking neighbors.

Not All Language Interpretation and Translation Companies Are the Same.

The Act expressly requires that health care plans use the services of "trained and competent" interpreters who can deliver "timely" services and who have fundamental knowledge in the languages of health care terminology and the concepts relevant to health care delivery systems and who also have education and training in interpreting ethics, conduct and maintaining confidentiality.

The foregoing contemplates that interpreters must be educated in health care terminology and concepts, must be HIPAA trained, and must understand the ethics, conduct and confidentiality of health care. Moreover, these interpreters must be "available," meaning, subject to scheduling. Absent interpreters who can meet these requirements, neither the spirit nor the letter of the Act can be satisfied. Therefore, the burden falls on health care plans to find interpreters who meet these qualifications if their plans are to pass the scrutiny, and obtain the approval of the DMHC.

Since most interpreters are provided through interpretation services, health care plans will need to find interpretation services that can arrange for interpreters who meet these qualifications, and that can provide ongoing training, supervision, scheduling and quality assurance.

Under California law, interpretation services can only meet these needs if their interpreters are employees of that company. Interpreters who are independent contractors rather than employees cannot be trained by the company offering their services. Nor can they be scheduled, or assigned, or in any way supervised or controlled. An interpretation company cannot review an independent contractor interpreter's performance, or require him or her to attend training, or to take part in meetings on performance issues. Nor can it exercise any form of quality control over the interpreter's service.

In the health care arena, it is critical for patient confidential information protected by state privacy laws, HIPAA and other federal laws to remain confidential. Interpreters engaged in this area, therefore, must be trained in and knowledgeable about these laws and their nuances. Indeed, the Act and its regulations expressly require such knowledge. They also must be trained in the ethics and course of conduct in health care, and must be subject to scheduling so that they meet the Act's requirement of being able to provide "timely" interpretation services at all of the points of contact whenever needed. Further, to ensure that the services are rendered in accordance with the health care plan's approved language assistance program policies and procedures, interpreters must

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be subject to review, supervision, quality control, and additional or expanded training as necessary to meet the standards approved by the DMHC.

This is where choosing the right interpretation service becomes critical to the success of a health care plan's language assistance program. Most interpretation companies have only a handful of employee interpreters, if any, and instead contract with independent contractors as a cost saving device, since the cost of having employees is so much greater. In order to maintain their classification of interpreters as independent contractors rather than as employees, the companies cannot treat these interpreters as anything other than contactors. To do otherwise puts the company at risk for wage act violations, unpaid taxes and penalties.

Thus, if an interpretation service trains, schedules, supervises, or otherwise places any obligations or controls on an independent contractor interpreter, it could be subjecting itself to significant negative financial burdens – forced to pay unpaid wages, unpaid taxes, and significant penalties, and defending wage act lawsuits -- that could significantly interfere with or prevent its ability to meet the needs of health care plans under the Act.

If an interpretation service that provides independent contractor interpreters wants to avoid these significant pitfalls, it must not engage in any training, supervision, control, scheduling or other conduct that could convert the contractor interpreter into an employee.[11]

Accordingly, a best practice for a health care plan seeking interpreters who will meet their language assistance program needs under the Act and who will pass the scrutiny of the DMHC is to engage the services of a language interpretation and translation service that can provide supervised health care industry/HIPAA trained employee interpreters in sufficient numbers on a timely basis 24/7.

[11]A White Paper entitled "Interpreting your Choices: A guide to understanding the difference between over-the-phone interpretation providers" which explores these issues in detail is available from the law firm of Fenton & Keller, Monterey California

Weinberg Legal Group, PC, based in Malibu, California, is the law firm of Steven M. Weinberg, who for over 25 years has been providing legal counsel to clients located throughout the United States and Europe primarily in the language interpretation, health care, telecommunications, advertising, entertainment, financial, food service, fashion and consumer products industries. Mr. Weinberg, who is admitted to practice in Arizona, California and New York, has been elected by peers year after year to be included in Best Lawyers in America, California Super Lawyers, and the International Who's Who of Business Lawyers. He also has served on many boards of directors, including the Translational Genomics Institute in Arizona and the International Trademark Association.

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