



Limited English Proficient Enrollee Access to Health Plan Grievance Systems

*An Assessment of Health Plan Compliance with
DMHC Regulations Title 28 Section 1300.68 (b)(3)*





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 responsive voice in health policy. We are a statewide network of multicultural health organizations, including community-based organizations, health care providers, and policy experts working together to develop and advocate for a proactive multicultural health agenda that advances the health of California's diverse communities. 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. Through a collaborative process with its partners in the African American, Asian and Pacific Islander, Latino and Latina, and Native American communities, CPEHN monitors, analyzes, and informs health care policies and legislation affecting minority populations.

Project Partners:

Asian & Pacific Islander American Health Forum

Asian Pacific American Legal Center

Health Access California

Latino Coalition for a Healthy California

Latino Issues Forum

Mexican American Legal Defense and Educational Fund

National Health Law Program

Western Center on Law and Poverty



Ensuring access to grievance procedures for Limited English Proficient Enrollees

Health Plans and the Department of Managed Health Care must do more

In an analysis of health plan reports to the California Department of Managed Health Care (DMHC), the California Pan-Ethnic Health Network (CPEHN) found critical limitations in the reports and procedures used by DMHC to ensure that all members of managed health care plans have full access to grievance procedures. In late 2002, DMHC issued regulations that included, among other provisions, requirements to ensure access to grievance systems for persons with Limited English Proficiency (LEP). The regulation also required health plans to report to DMHC on their compliance with this aspect of the regulations. This policy brief provides a description of the shortcomings of the current compliance procedures and provides solutions to address those problems. Our recommendations will enable health plans and DMHC to improve services to LEP enrollees.

The relevant text of Title 28 Section 1300.68(b)(3), which went into effect on December 12, 2002, is as follows:

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



Language access is essential for quality health care

The 2000 Census reported that a majority (53%) of California's population are people of color and that almost 40% of Californians speak a language other than English at home. Studies have shown that the lack of language services limits access to health care and preventive care services,¹ often results in preventable use of emergency departments,² impedes patients from comprehending diagnoses and asking questions,³ and increases the likelihood of patients missing appointments.⁴ In a survey of providers, over 70% report that language barriers compromise the patient's understanding of treatment advice and their disease, increase the risk of complications, and make it harder for patients to explain their symptoms.⁵ Misunderstandings of cultural practices and beliefs can result in serious injury and even death to the patient.⁶ To ensure access to quality health care for all their enrollees, health plans and providers must remove barriers to communications and gain an understanding of how culture strongly influences the perception of disease, attitudes toward prevention, and other health-related behavior.

SB 853 will improve language services

The findings and recommendation in this brief will help inform the implementation of Senate Bill 853, authored by Senator Martha Escutia and sponsored by CPEHN, the Western Center on Law and Poverty, and the Mexican American Legal Defense and Education Fund. SB 853 was signed into law in 2003 and requires DMHC to develop regulations by 2006 to ensure LEP access. These regulations will define: (1) requirements for access to health interpreters, (2) training and performance standards for health interpreters, (3) requirements for informing enrollees of their right to access interpreters, and (4) standards for the translation of documents.

The law requires health plans to report to DMHC on their efforts to improve the provision of care for persons of diverse backgrounds. SB 853 will also require DMHC to modify audit tools to survey health plan compliance with the regulations.⁷

CPEHN found shortcomings in current practices

CPEHN's analysis of health plan compliance reports found shortcomings in the oversight policies and procedures used by DMHC and in the practices and procedures reported by health plans.



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The reports from the managed care plans demonstrated a wide variance in the descriptions of how plans addressed the requirement to make grievance processes LEP accessible and a lack of clear adherence to best practices in the area of cultural and linguistic services. The ability of an enrollee to communicate effectively with their health plans concerning grievances is essential. Therefore, DMHC must refine its oversight processes to gather the information it needs to fully enforce the access to grievance system regulation.

The information contained in health plan reports varied widely

CPEHN reviewed 82 health plan reports submitted to DMHC to assess the accessibility of health plans' grievance system to LEP enrollees. As a result of the variance in reporting, the reviewers could not fully assess the compliance of health plans with the regulation. All of the plans reported that enrollees have access to interpreters, but details such as how enrollees and contract providers are informed of the availability of interpretation services were often not reported. Most health plans reported using bilingual staff or external interpreter services for meeting the language needs of their enrollees. Only 70 of the 83 plans explicitly reported that they have translated grievance-related documents available for enrollees, even though the regulations specify that this is required. Only 22 plans provided a list of the languages into which the grievance documents are translated.



DMHC does not verify information reported by the health plans

The inconsistency and shortcomings of the information provided in the health plan reports indicate the need for independent validation of their contents. Recognizing some of the problems with health plan reports, DMHC conducted a follow-up email survey of health plans asking three specific questions relating to LEP access to their grievance systems:

- Are translations of grievance procedures, forms, and plan responses to grievances available to enrollees not proficient in English?
- Do enrollees have access to interpreters to assist them with the grievance process?
- Has the plan developed a policy describing how the health plan's grievance system complies with this regulation?

If a health plan answered yes to the questions, the plan was deemed in compliance. If a plan did not answer yes to all of the questions, DMHC staff continued an e-mail dialogue with the plan until the respondent could answer all questions affirmatively.

The approach taken by DMHC to gather and update information fails to

provide even minimal validation of health plan claims that limited English proficient enrollees have adequate access to the plan's grievance process. First, the reports made by plans after prompting may be based on what they plan to do and not reflect current practice. Second, even when plans have policies and procedures in place to provide access to grievance systems, telephone and written reports do not allow a determination of the degree to which plan staff comply with those written plan policies. This should be accomplished through on-site audits, which can also provide valuable information about the impact of compliance with the regulation on patient services and plan operations.

Some health plans fail to adhere to acceptable practices

Two commercial health plans reported that they ask enrollees if a family member or friend is available to act as an interpreter *before* the plan offers to provide an independent interpreter. Use of family and friends as interpreters risks the possibility of inaccurate interpretation and breach of confidentiality. Even if the enrollee would like to have another person present during grievance procedures, an independent trained interpreter provides the best method for ensuring information is communicated accurately and confidentially.

Solutions: DMHC should improve reporting, enhance oversight, and promote adoption of best practices

CPEHN recognizes that DMHC considers compliance with this regulation to be important and that plans need to be encouraged to and educated about how they can comply. As California's populations continues to grow more diverse, DMHC will need to incorporate provisions related to LEP access into many, if not all, new regulations, in addition to those required by SB 853, and aggressively ensure compliance. To this end, CPEHN proposes the following solutions to enhance plan compliance and monitoring.

Improve Reporting

Future health plan compliance reports for regulations related to LEP access must include the following information on the plan's policies and procedures:

1. How enrollees are informed, in their preferred language, of the availability of interpreters and translated documents.
2. How the language of enrollees is tracked through the health plan system and at the provider level.



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3. Documents that are immediately available in translated format, documents that are only translated upon request, and the languages into which each set of documents are translated.
4. How enrollees are informed of changes in language access policies.
5. Specify how plan and provider care givers and administrative staff are informed of the availability of interpreters and the procedures for their use.

Health plans that have multiple lines of business, such as covering Medical and Healthy Families enrollees, should also specify if LEP access procedures and policies vary based on the program into which individuals are enrolled. They should also describe how cultural and linguistic services for LEP enrollees in non-threshold language groups differ from those in threshold language groups. Some health plans included most or all of this information their reports to DMHC.

Improve oversight

DMHC should incorporate assessment of LEP access into its on-site audits. The inconsistency of health plan reports calls into question their reliability as a monitoring tool. It is a significant oversight that DMHC's audit tools have yet to be modified to assess compliance with the LEP access requirements in the grievance regulations, which have been in effect since 2002. Each time DMHC issues new regulations the auditing tools must be appropriately modified. SB 853 requires DMHC to modify its audit tools to assess compliance with LEP access standards. DMHC should develop and test appropriate tools as early as possible so that health plans can develop a better understanding of these new requirements and identify best practices.



Adopt Best Practices

DMHC should encourage managed health care plans to adopt the following cultural and linguistic best practices, including:

1. Except in the case of extreme medical necessity, discourage family members and friends from serving as language interpreters. Family members and friends should not be allowed to interpret unless specifically requested by the enrollee after being informed of the availability of a trained interpreter and told of the disadvantages to using family or friends.
2. Enrollees should not be required to pay extra charges for utilizing languages services.
3. Encourage/require health plan staff to receive cultural competency, cultural awareness, and diversity training. Staff participation in this type of training should be documented and rewarded.

4. Ensure that enrollees of color and LEP enrollees have equal access to health care services, support services, health education and grievance systems.
5. Collect and use race and ethnicity data to identify trends in the patterns of grievances filed by LEP enrollees and enrollees of color and the outcome of those grievances.

Continued Advocacy Will Enhance Access to Quality Healthcare

CPEHN and its project partners will continue to collaborate with DMHC to enhance access to quality healthcare for culturally and linguistically diverse enrollees.

We have worked closely with DMHC since its creation in 2000 as the first-in-the-nation consumer rights government agency designed to help California consumers resolve problems with their HMOs and ensure a better managed health care system.⁸ We will continue to advise DMHC on issues related to the improvement of the health of California's communities of color. We will also continue to advocate for the development of cultural and linguistic requirements integrated into patient care and enrollee rights regulations promulgated by DMHC. And, we will continue to monitor and assess the effectiveness of DMHC strategies to monitor and audit health plan compliance with regulations. The analyses and recommendations in this policy brief are key elements of this ongoing effort.



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¹ Woloshin, S., et. al. "Is Language a Barrier to the Use of Preventative Services?" *JGIM*, 12: 472-477, August 1997.

² Manson, A. "Language Concordance as a Determinant of Patient Compliance and Emergency Room Use in Patients with Asthma," *Medical Care*, 26 (12), p. 1119-1128, December 1988

³ Smith, M. and Ryan, A. "Chinese-American families of children with developmental disabilities: an exploratory study of reactions to service providers," *Mental Retardation*, 23: 345-350, 1987.

⁴ Manson, A. "Language Concordance as a Determinant of Patient Compliance and Emergency Room Use in Patients with Asthma," *Medical Care*, 26 (12), p. 1119-1128, December 1988. And

Woloshin, S. and Bickell, N. "Language barriers in medicine in the United States," *Journal of the American Medical Association*, 273: 724-727, 1995.

⁵ Robert Wood Johnson Foundation, "New Survey Shows Language Barriers Causing Many Spanish-speaking Latinos to Skip Care," Media Release, December 12, 2001.

⁶ Fadiman, A. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*, New York: Farrar, Straus, Giroux, 1997.

⁷ Federal law requires that enrollees in public programs have access to linguistic services. The Medi-Cal Managed Care Division of the California Department of Health Services conducts audits of health plans' Medi-Cal lines of business to ensure compliance with cultural and linguistic requirements in their contracts with the state. However, there is currently no auditing for LEP access in individual- or employer-based health plan coverage, or coverage through the Healthy Families program.

⁸ More information about DMHC can be found at www.hmohelp.ca.gov



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California Pan-Ethnic Health Network

654 13TH Street
Oakland, California 94612

(510) 832-1160 TEL

(510) 832-1175 FAX

info@cpehn.org

www.cpehn.org