Provider Group Frequently Asked Questions
Health Plan Implementation
of the Department of Managed Health Care's (DMHC) Language Assistance Program

1. What are the DMHC Language Assistance Program Regulations (previously referred to as SB853)?

Effective January 1, 2009, in accordance with Section 1367.04 of the California Knox-Keene Act, the Department of Managed Health Care regulations – Section 1300.67.04, Title 28, California Code of Regulations -- require that health plans establish a Language Assistance Program ("LAP") for enrollees who are Limited English Proficient ("LEP"). (Similarly, the California Department of Insurance promulgated its own LAP regulations, in accordance with Sections 10133.8 and 10133.9, California Insurance Code – see Section 2538, Title 10, California Code of Regulations.) Note this regulation only applies to Knox-Keene licensed plans, such as Healthy Families & Healthy Kids, and not Medi-Cal or Medicare.

A Limited English Proficient (LEP) enrollee is "an enrollee who has an inability or a limited ability to speak, read, write or understand the English language on a level that permits that individual to interact effectively with health care providers or health plan employees."

Each health plan's Language Assistance Program (LAP) must include the following:

- Written policies and procedures
- Assessment to identify enrollees' spoken and written language needs
- Demographic profile of the health plan's enrollee population, including enrollee race and ethnicity
- Identification of the health plan's threshold languages (language(s) other than English spoken by a specific proportion, defined by the law, of the health plan's enrollees)
- Translating vital documents at no charge to the enrollee (*translation refers to the transfer of the written word to one language to another*)
- Providing interpreter services at no charge to the enrollee at all points of contact, administrative and clinical (*interpreting refers to the transfer of spoken word from one language to another*)
- Informing enrollees of the availability of language assistance services
- Proficiency and quality standards for translation and interpretation services
- Training of health plan staff on the LAP and cultural diversity of the health plan's enrollee population
- Compliance reporting and quality monitoring

2. What is the individual provider's role and responsibility regarding the health plan's Language Assistance Program?

A provider's responsibility for language assistance will depend upon their contractual arrangement with each health plan. But at a minimum, providers will need to cooperate and comply with the health plan's LAP services by facilitating a LEP enrollee's access of a health

plan's LAP services – particularly a health plan's oral interpreter's services – in the clinical setting.

3. What is a threshold language and how is it calculated?

A threshold language is a language other than English that is spoken by the proportion of the health plan's enrollees meeting the following thresholds.*

Number of health plan enrollees	Number of threshold languages	Number of additional languages
1,000,000+	Top 2 languages other than English preferred by health plan enrollees as determined by needs assessment.	Any additional languages needed by 0.75 percent or 15,000 of enrollees, whichever is less
300,000 to 999,999	Top 1 language other than English preferred by health plan enrollees as determined by needs assessment.	Any additional languages needed by 1 percent of 6,000 of enrollees, whichever is less.
Less than 300,000	Any language other than English as shown to be preferred by 5% or 3,000 of enrollees, whichever is less.	N/A

* Excluding Medi-Cal enrollees and treating Healthy Families Program enrollees separately.

4. Where can we find out what each health plan's threshold languages are?

You may find a health plan's threshold language(s) on the ICE Website at:
http://www.iceforhealth.org/library/documents/Healthplan_CA_LAP_Contact_Sheet.xls
You may also contact the health plan directly.

5. What is a vital document?

The following documents are vital documents when produced by a health plan (i.e., plan-produced documents), including when the production or distribution of a vital document is delegated by a health plan to a provider group or administrative services provider:

Most likely to apply to Provider Groups:

(A) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal; [1]

(B) A health 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;

[1]Claims denial letter templates are available at <insert ICE website>; UM denial and pend letter templates are available at <insert ICE website>

Health Plan specific:

(C) Notices advising LEP enrollees of the availability of free language assistance and other outreach materials that are provided to enrollees; [2]

(D) Applications;

(E) Health plan consent forms, including any form by which an enrollee authorizes or consents to any action by the health plan; (excludes consent forms used by medical providers)

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

(G) The enrollee "Benefit Matrix" disclosures required by Section 1363(a)(1), (2) and (4) of the Knox- Keene Act.

[2] Plan Specific Language Assistance Notices <insert ICE website>

6. What is a Language Assistance Program (LAP) Notice? With what documents do I include the notice?

Health plans will use a Language Assistance Program Notice to inform their enrollees of the availability of language assistance services (e.g., oral interpretation and written translation services).

Additionally, enrollee-specific vital documents produced in English will include a notice that offers assistance to interpret the document in any language or to translate the document into the health plan's threshold language(s). Documents automatically sent in threshold languages do not require the LAP notice. Apply the notice to the following enrollee-specific vital documents often produced by Provider Groups as part of their UM and/or Claims delegated administrative activities:

- Examples of Enrollee-specific vital documents include:
  - For UM or Case Management Department: Denial letter, Delay letter, Modification letter and Termination letter.
  - For Appeal & Grievances Department: Appeal Acknowledgement Letter, Appeal Uphold letter, Grievance Acknowledgement letter and Grievance Resolution letter.
  - Claims processing letters or EOBs if a response is needed from the enrollee.

7. How does a provider obtain translation or interpretation of a provider group-issued vital document from the health plan if requested by a health plan member?

The provider group will need to provide a copy of the document to the health plan in a timely manner, upon request.

Timeliness standards are necessary to ensure that the requested document is translated within the 21 calendar days as required by the regulations. Therefore, upon the request from a LEP member, a provider group will be required to forward the requested enrollee-specific vital document (e.g., a service denial letter) produced by the provider group to the health plan within the following time frames:

- Urgent request or service: One business day
- Non-urgent or post-service request: Two business days

For health plan specific information regarding how to arrange for language assistance services from a health plan, please refer to the ICE Health Plan Resource Guide for Provider Offices: **http://www.iceforhealth.org/library/documents/Healthplan_CA_LAP_Contact_Sheet.xls**

The guide also lists health plan contacts should you have any questions. For documents sent via e-mail, follow your procedures to ensure the protection and security of patient medical information (Protected Health Information, PHI), by adhering to your organization's security protocols (e.g., sending encrypted files).

8. How do I get an oral interpreter service from a health plan?

In most cases the health plan will offer telephonic interpreter services.

For health plan specific information regarding how to arrange for oral interpreter services from each health plan, please refer to the ICE Health Plan Resource Guide for Provider Offices **http://www.iceforhealth.org/library/documents/Healthplan_CA_LAP_Contact_Sheet.xls.** The guide also lists health plan contacts should you have any questions.

9. Can I use my own bilingual staff to interpret?

From a health plan's perspective, it is strongly recommended that providers help LEP members access the health plan's qualified interpreter services and make informed decisions about when to use highly skilled, qualified health plan interpreters, a service which is available at no cost to LEP members or providers. The health plan's interpreters are trained in medical and insurance terminology, in addition to being proficient in—and culturally sensitive to— diverse ethnic and linguistic nuances. LEP members may prefer to rely upon the objectivity, accuracy, and confidentiality of professional interpreter services. However, if the LEP member refuses to access the health plan's interpreter services, it is recommended that the provider document that refusal in the member's medical record. The law neither requires a LEP enrollee to access the health plan's interpreter services, nor prevents a LEP enrollee from speaking with bilingual provider staff. However, the law does obligate health plans to provide and monitor the delivery of the health plan's qualified interpreter services to LEP patients at all points of contact (administrative and clinical) in order to ensure meaningful access to health care.

10. Do these regulations prohibit family members from serving as interpreters for enrollees?

No. Family members are not banned from serving as interpreters for enrollees under this legislation; however, health plans must ensure that its LEP members are notified of the availability of health plan free, quality language assistance (interpretation and translation) services. Should a LEP member refuse to access a health plan's language assistance services, then it is recommended that the provider document that refusal in the patient's medical record.

11. Which staff need to be educated regarding the LAP program?

To ensure compliance with the law, health plans must ensure that its staff – and any staff the health plan contracts or delegates as part of the provision of its LAP services -- who interact with LEP enrollees be educated on the health plan's Language Assistance Program and how to obtain LAP services from the health plan.