

Medi-Cal Language Access Services Task Force

August 20, 2007

Meeting Notes

I. Welcome / Introductions / Administrative Items (Co-Chairs):

Prior to beginning the meeting, Co-Chair Carolyn Castillo Pierson announced to the task force that she would be leaving state service and would no longer be serving as Co-Chair of the MCLAS Task Force (TF). Carolyn has accepted the Executive Director position for the Yolo Family Resource Center. Task Force members wished Carolyn much luck and congratulations on her new position. As a follow-up, Lupe advised TF members that she would be meeting with Sandra Shewry to discuss a follow up on an interim co-chair. Lupe advised members that there were two issues: replacing and naming an interim Director and to name a co-chair. Lupe advised TF members that she would keep them informed as changes were announced.

A. Introductions – see sign in sheet

TF Members, guests and stakeholders introduced themselves and the organizations they represent.

B. Meeting Objectives

Co-Chairs advised TF members that the primary objective of the meeting was centered on finalizing decisions outlined on the agenda in addition to two presentations that included the managed care perspective in order to begin educating TF members on managed care for the pending recommendation.

C. Administrative

Administrative: Lupe also provided an overview on the Timeline document and advised TF members that copies of the Steering Committee (SC) meeting notes had also been included in with the other meeting materials in order to keep TF members apprised of the decisions that were being made at the SC level.

Lupe provided an overview on what had been discussed during the last SC meeting that included the decisions that still need to be made (*see*: Timeline, version 8/17/07). Advised TF members one of the few changes having been made was regarding the outline deadline which has been moved to September 11th, 2007 in preparation for the upcoming meeting with Sandra Shewry on October 2, 2007. All members of the Steering Committee members are invited to participate.

Report Structure: Based on its previous meeting where the report structure was brainstormed, the SC developed a proposed structure for the final report. Lupe provided an overview to TF members on the different sections and provided an explanation for each section. Additionally, the Co-Chairs advised TF members that it was assumed that different organizations would be signing off to the document and a more in-depth conversation will be had at the next TF meeting after major decisions have been finalized. Members asked for more information on the process for drafting and Lupe advised members that WG chairs were generally responsible for the recommendation section but would likely work with individual WG members to complete the section. Due to time limitations and the fact that all TF members had not had the opportunity to review the proposed report structure provided by the SC, Lupe advised TF members to discuss any additional questions through individual WG chairs.

Co-Chairs also advised TF members that some initial discussion had begun around the issue of hospitals and possibly hold separate meetings as has been had with managed care plans. Lupe advised TF members to follow up with the following individual TF members on the following issues:

- Hospitals –Wendy Jameson
- Mental Health – Rachel Guerrero

II. Workgroup Break-Out Session(s) – please see notes for individual workgroups

III. Decisions

David advised TF members that the same process used during the last TF meeting (on 6/29/07) would again be utilized to review the decisions made during this meeting.

(Please note: During the last in-person TF meeting, the TF facilitator, David Nakashima provided colored index cards representing the following:

- Green = support
- Yellow = support with reservation(s)
- Red = do not support

The TF adopted a consensus decision-making structure to be supported by a majority vote as 2/3rds of a quorum lacking a consensus.)

Decision #1: Reimbursement of Billable Services

Lupe presented the one-page draft recommendation that the WG had compiled on billable services including contracted interpreters, phone interpretation, VMI interpretation, bilingual personnel and issues that were out of scope. The Cost-Finance WG recommends that phone and VMI services be reimbursed by the minute and bilingual personnel should be reimbursed through use of a “T-Code”. Lupe advised TF members that a T-Code accompanies other medical service reimbursement codes and enhanced services such as language access. Lupe advised TF members that the decision for contracted interpreters would be presented at the October TF meeting.

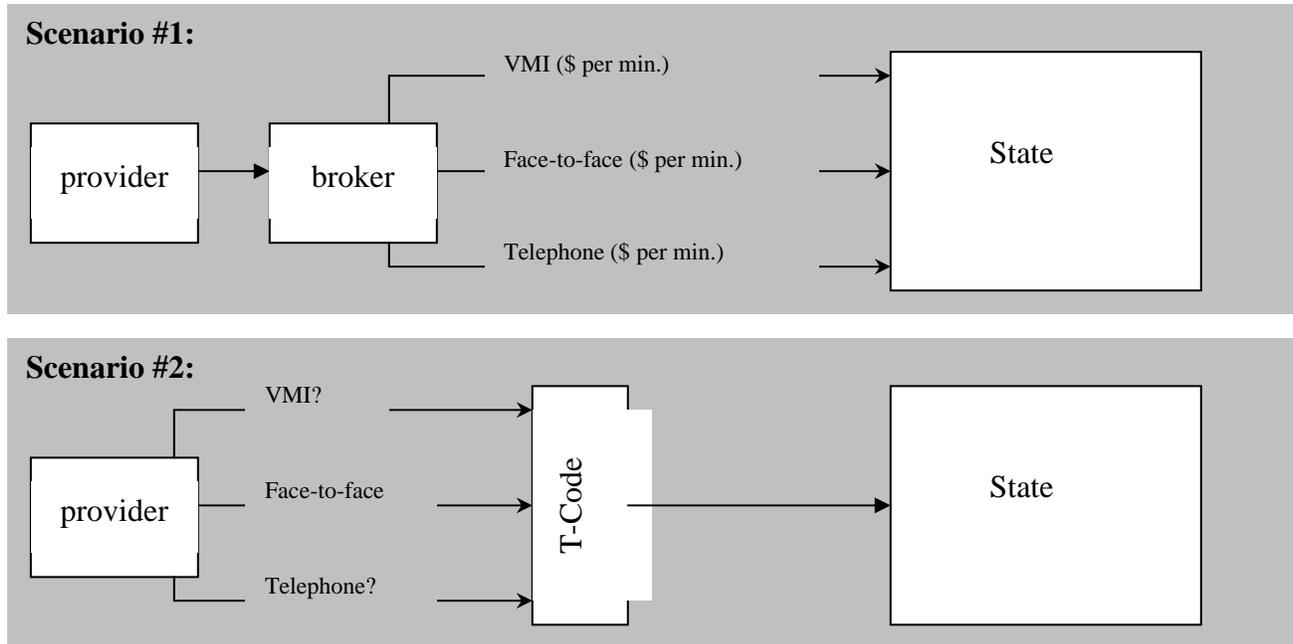
Comments & General Discussion:

TF members discussed several aspects of the proposals that included whether providers can, according to our existing healthcare system, bill for extended time. Members discussed whether including specific language on covering extended time beyond the cost of direct services should be added. Co-Chairs advised that there was not sufficient information to include that in the recommendation.

TF members still had a number of questions regarding use of the T-code and its specific interaction within different types of interpretation. Lupe summarized according to the following:

- bilingual personnel – use T code (outside the broker system)
- bilingual provider – use T code (outside of the broker system)
- broker – reimbursed by state for each encounter

	<u>Broker:</u>	<u>Provider Closed System:</u>
Contracted	X	X
Phone	X	? Check with CMS
VMI	X	? Check with CMS
Bilingual staff	X	X
Bilingual providers	X	X



After ensuing discussion, there were specific questions that TF members identified that still need to be resolved on this recommendation, including:

1. Set up costs for VMI – Would set-up cost(s) be included or covered?
2. T-Code and telephonic interpretation, VMI – Can a T-code be used for this type of interpretation?
(Co-Chairs advised that that would likely require an additional conversation with CMS)
3. What is the financial value of the T-Code?
4. How can provider use T code and administrative services?
5. Provider and extended time

Other Issues Raised:

For in-house interpreters, can they bill on their own?

Lupe advised TF members that the T-code only applies if a physician is billing on their own. The TF generally agreed that an additional conversation would need to occur with CMS to ascertain whether VMI and telephonic interpretation would also qualify for reimbursement. TF members discussed the difference in a system where, if provider wanted to make their own arrangement, there would exist a mechanism for them to get their own reimbursement (including own interpreter, etc).

Some TF members appeared to be somewhat confused about the final recommendation and the TF facilitator, David Nakashima reoriented the group by asking a TF member to restate the model being proposed to ensue that everyone had the same interpretation of the model. A TF member summarized the proposed hybrid model by stating that there are two venues under the delivery model. Under the first venue, a broker enables all types of interpreter services, include in-person,

telephonic, and VMI. In the second venue, a provider can be reimbursed for interpreter services through use of a T-code with some question remaining on whether VMI and telephonic interpretation can also be reimbursed through use of a T-code.

Initial Survey:

When asked, Members generally agreed to the concept of the intent of the recommendation with some discussion (see below).

- Clarity is needed around the questions already identified
- Need to determine input from outside stakeholders, such as mental health providers
- Can a healthcare system bill for a variety of way in which services are provided just like a broker. Can a different system be designed for hospitals? Is it sustainable?
- Do situations exists where a T-code reimbursement can be higher than reimbursement for actual medical services? Does this lead to recommendation of a rate that is unreasonable?

Members agreed that an assumption of this recommendation included the requirement that all interpreters be certified.

Decision #2: Quality Advisory Board (QAB)

As a follow-up to the last TF meeting, the Quality and Standards Workgroup (WG) has developed the following recommendation on the both the responsibilities of the QAB as well as its composition. Carolyn presented in lieu of the WG chair and advised TF members that, according to the compiled one-page recommendation, the QAB will be established by the Department of Health Care Services and will determine the final composition of the QAB. Additionally, under the recommendation, the QAB will essentially oversee the implementation of language services, including the development of policies and procedures, certification, as well as inform the RFA and advise upon certification fees for interpreters.

TF members raised some questions regarding managed care and the focus around fee-for-service, particularly many managed care plans are in the process of determining individual processes (including training, certification, etc.) required under SB 853. Carolyn reminded TF members that the implementation of SB 853 affects managed care on commercial side only, and does not address requirements for Managed Care plans under Medi-Cal. Additionally, she reminded TF members that no final recommendation has been made by the TF regarding managed care plans, though a recommendation should be forthcoming shortly. As a result, she advised TF members to assume that this includes both fee-for-service and managed care plans.

Decision:

David queried the group to determine support for this decision. Members agreed to the content contained within the QAB recommendation.

Carolyn advised TF members that she recognized that there is still the need to answer questions related to oversight and where/how oversight will occur.

Decision #3: Standard Competencies for Healthcare Interpreters

Similar to the previous decision, Carolyn also presented the third recommendation on standard competencies for healthcare interpreters. The recommendation includes defining the role of health

care interpreters in terms of accuracy, consistency, cultural competence and understandability. Additionally, the recommendation identified broad area of core competencies that should be expected of interpreters that included:

- Processing information such as listening comprehension, anticipating
- Interpersonal such as self-awareness, tact and ability to maintain confidentiality
- Specific linguistic skill beyond grasp of language and rules of grammar such as overall effective communication
- Basic of professional interpretation to include standards of practice, ethics and modes of interpreting
- Knowledge of health and medical terminology
- A systems understanding of patients, interpreters and language service brokers
- Sensitivity to and awareness of cultural differences

In this instance, the state would develop standard competencies and will include processes for oversight of training programs with the state taking the above criteria into consideration. TF members discussed the recommendation and suggest that HIPPA requirements would need to be integrated into the requirements. Other TF members raised the issue of confidentiality and instances in where rare languages may result in situations where the interpreter and the patient may know each other. TF members asked what additional protections would be embedded into the process for patients.

TF members also discussed the training aspect. The state today, currently has a variety of training programs, with little-to-no consistency across the board on what individual training programs look like. TF members agreed that this would require further discussion and could possibly be given to the QAB for consideration.

Decision:

David queried the group to determine support for this decision. Members agreed to the content on the recommendation one-pager.

Decision #4: Broker Selection Process

Based on some recent discussion had by the Delivery WG during the preceding break-out session, Vivian Huang, Chair of the Delivery WG, presented the revised recommendation that included feedback from individual WG members.

The recommendation essentially identifies the criteria brokers must meet in order to be eligible to become a broker. The recommendation directs the Department of Health Care Services to establish and oversee the RFP process. While the recommendation does not detail the requirements under the RFP, the WG did want to provide the state with some parameters. Accordingly, brokers are must be able to use of variety of methods and meet incoming requests, must maintain access to phone interpretation service, ensure that all interpreters are certified, must handle reimbursement and provide streamlined services (eg: one phone line). Also included in the recommendation is a process for monitoring services and recruiting specific interpreter for rural languages. Brokers must also have a history of working with diverse communities and working w/in California.

Initial Survey:

When asked, Members generally agreed to the concept of the intent of the recommendation with some discussion (see below).

Comments & Issues Raised:

Carolyn advised TF members that she had created a timeline for the development of RFPs and advised TF members that she would forward to group.

Some TF members advised that they would like to have a time limitation embedded in the RFP that would require some type of biennial review. Other members also raised the issue of perhaps needing additional oversight during the early months of the contract, particularly as the broker system is getting started. TF members raised the issue of incorporating patient feedback into the model that could be used to evaluate brokers. Other TF members suggested that data collection and evaluation of that type may not be doable in a one-year timeframe. Some TF members suggested that brokers be given enough time look at different aspect and give them enough time to review and provide feedback.

Carolyn advised TF members that procurement of this magnitude would not be an easy task for the state and that some amount of “shelf life” might be needed. She advised TF members that there would also be some investment on the part of the broker, who would largely be responsible for developing and implementing the infrastructure needed to run this type of system. If the requirements are front-loaded, it is doubtful that many would actually consider taking on the financial risk without a guarantee that they would be able to provide the service. She expressed concern that there would be an RFP without any takers. She suggested that brokers can and should be evaluated and audited but suggested that the timing of those features should be taken into consideration, including the possibility of having a longer contracting period. Other state representatives on the TF agreed, with some input that most contracts require a minimum of three years. State staff members advised of the following process for contracts: Every contract has a term and an extension (eg: three year contract with two two-year extensions for a total of seven years). A second procurement, with little to no change on the requirements could be cut down to 15 months. However, staff cautioned that various protocols, including a notification period of 10-months of not renewing, would be needed. Additionally, staff advised that state contracts usually include some safety mechanism and do not normally cancel without reason. While organizations can typically appeal, procurements are very sensitive, with state particularly sensitive to the possibility of a lawsuit. State staff advised that some type of monitoring can be included, such as a probationary period. Staff suggested that the TF may want to be more specific for looking at quality standards and instead allow the state to determine contracting time periods. Vivian advised that she would be removing any indication of time markers and would instead incorporate the larger discussion around monitoring and probationary period.

David Nakashima, the TF facilitator, queried TF members to see if any other issues remained on this decision. Other issues identified by TF members:

#1: Issue of Quality

- Mechanism to Affirm
- Specific to language services
- Test for skills of interpreters
- Test Development (things to test for):
 - Cultural competency
 - Self-awareness

- Issue with “demonstrated” skills
- Issue with “start-up” period of the test
- Accreditation
- Core competencies – lack of an agreed upon way to test fro them.

#2: Make Recommendations About Pilot (or stay silent)

- Broker / Contract and Regional Areas
- Fiscal Piloting

#3: In Report:

- Prioritize parts of the system
- Prioritize areas

#4: Frame as “phase-in” not a pilot (not implemented, then goes away)

#5: Have a ‘Big Picture’ first – roll out or phase in

#6: Where do you want to take this?

- Which area/county?
- Too big/too small
- Where is the biggest hole in services?

#7: Risk factors in not doing this

#8: Cost

David also queried the group to see what would more would be needed in order to complete the report. Issues raised by TF members:

- Need to define outcomes as a function of why this function is important, if there are risk cases, someone should take three or four cases and addressing this as a problem, early in the report (risk cases)
- Need clarity on justification pieces and background on why this particular model is utilized over other sate models
- Need additional statistical information and places to direct questions regarding numbers and statistics provided in the argument
- Need additional data on language preference within the system.
- Glossary or definitions should be included

TF members were reminded that a first draft of the report is due September 11th.

IV. Notes from the Field:

Lupe advised TF members that there would be two presentations from Nai Kasick from L.A. Care and the second presentation from Vanessa Baird with the Department of Health Care Services. This issue is related to the determining how managed care fits in with the suggested delivery service.

L.A. Care Health Plan (*please see presentation handout*):

LA Care was created in 1994 and became licensed in 1997. In reviewing the plan’s enrollee demographics (slide #3), TF members raised question regarding languages. Nai advised TF

members that the program's largest spoken language is Spanish. Members discussed the different types of languages found within their membership.

In looking at the information on race (slide #3), Lupe asked if there was concordance between language and race and Nai advised that there was a correlation between the different groups. She provided an overview of the data included in the slides. TF members asked what percentage of Spanish speakers actually need language assistance and presenters advised that it is about half of the membership that need or are actually (limited English proficient) LEPs that need language assistance. Members asked if that also held for other races. The presenters suggested that Spanish speaking may be skewed and is related to specific races. Certain languages may vary, such as Cambodian.

The presenters advised TF members that they do test for bilingual proficiency, provide training around cultural competency, both for plan partners as well as internal staff. L.A. Care also provides oversight to PP and PPGs to ensure they have and provide adequate access. TF Members asked what type of interpreters are used and the presenters advised that outsider contractors are used. Currently, LA Care has a one-size-fits-all approach, but they may be in the process of changing that. The lowest rate paid to their contractors is \$65 per hour, in terms of working with a community-based organization (community agency). For less common languages, the rate is up to \$80 with a two-hour minimum for \$120. For certain conferences, contractors generally charge per half day which is \$295 in a language such as Spanish, with approximately 60% of the fees going towards the interpreter (approximately \$30 per hour).

The presenters advised TF members that the plan's Vendor and vendor pools likely need review. In their experience, they have found that if there is over-reliance with a vendor, they begin to become lackadaisical and may begin to price gouge. They advised that it is important to have a mix of vendors and begin to streamline processes in order to make things more efficient.

The presenters advised TF members of the following requirements that L.A. Care observes, for those wanting in-person interpreting:

- Require a 72-hour notification
- Written translation – have an internal policy that provides guidance, with requests that come in
- Have distinctions with smaller documents versus larger documents

Translation Requirements:

- Plan partners requirement – outline documents that are required
- Reviewed materials and division of labor
- Review of documents and trend in steady increase (focuses on 2006 in-person interpretation)
- Usage – they are at triple than where they were five years ago

Alternative Formats:

- Audio, Braille, large font in other languages, threshold languages for largely older and senior populations

TF members posed several questions to the presenters that included the following:

- Do you help your partners with consent forms, etc.
Response: if it is used by the entire system – yes, otherwise, no.

- The need for provider education seems to be an issue that continues to arise. How does LA Care manage this issue?
Response: They are a delegated model where it might be easier to conduct a physician forum where physicians can receive information from LA Care that includes training, etc. A representative of the Cultural & Linguistics Services always attends in order to reinforce training around cultural competency and linguistic services. The presenters advised that they see this as an ongoing effort.
- Often, physicians do not have the time to the time to attend or participate. How do you address this with your physicians?
Response: L.A. Care is sensitive to this issue and is accustomed to going out to different sites to conduct on-site training.
- For physician advisory group mentioned previously, what is the attendance?
Response: Approximately 30, high volume doctors. The presenters also advised that they have large conferences with CMEs and have units under their organization in order to do site visits with physicians to provide general orientation and education. For health services areas, they also have a team that reviews services available to them. The presenters advised that they pursue a combined blanket and customized approach per provider.

Medi-Cal Managed Care, Department of Health Care Services

Carolyn introduced Vanessa Baird, Director of the Medi-Cal Managed Care (MC MC). Carolyn reminded TF members of previous discussions that have included how MC MC can be included with the recommended system. Carolyn advised Vanessa that the TF would like more information on how capitation works, how integration might happen across product types and review of the two options to either #1) adjusting the capitation rate and #2) to carve out MC MC services. Vivian Huang, Chair of the Delivery Workgroup (WG) added that the preference or the direction that the WG is looking at maintaining what the group already has, but perhaps looking at changing capitation rate and as a tool.

Vanessa advised TF members that the capitation rates for 2007-2008 rates have changed, including how they were working which is different from how they will continue to work. Currently, managed care plans have a per-member, per-month rate with different pay rates. Those members have different aid codes (a family) than if you are a senior, etc. For seniors, they tend to cost more and, as a result, will be different. Currently, the department is looking at cost and utilization data, services provided and how much they spent against regularly reported ad hoc reports to coincide with contract data. All current Knox Keene licensed plan have a contribution as a reserve that they are required to have.

Vanessa advised TF members that language services would likely fall under the administrative cost. She advised that this is determined by how the plan captures the cost. If they pay for it, they will reimburse them for it, with the cost likely coming up in their monthly data reports. If they access those services, those are costs that they are not incurring directly.

Overall, the department also looks at bi-annual information on cost. If plans are paying for a contractor, this will show up on the cost data. She advised that the department will likely be looking at overall 'reasonableness' and will individually determine a plan-by-plan administrative cost per plan. For example if a plan spends 4% for direct care cost for senior. (She noted the following: There is always a danger, when adding a percentage to a direct cost in possible overpayment to a plan.) If plans are paying higher fee, if they are providing translation services, that would get captured in cost data.

She cautioned that there is often difficulty with health plan data that is on-time real time. There is a lag, with a reasonable data pool of approximately 18 months. This often involves a risk of skewed data in the first start up period. If technically, the state is paying for the services that will be provided by broker there may be some misdirection of funds. She advised, however, that eventually, the lag will catch up to the plans.

Currently, the department does not single out language services. Rates are calculated once a year, unless a situation occurs that would call for an adjustment of the rate. Vanessa advised TF member that it is up to the plan to determine whether the amounts are sufficient. Previous rates were not tied to a plan's cost. As of today, this is the new methodology. If you are a plan that has a high administrative rate (eg: 20%), they won't receive a full reimbursement, based on what other plans have as their threshold. Currently, none of the plans know what their rates are, as the plan is new.

In general, Vanessa stressed that plans' costs must be reasonable. She advised that MC MC often pays more to specialty care and therefore do not mirror fee-for-service spending. Additionally, plans are able to spend their money where they wish, however, the state will compare this spending by the spending of their peers (for example, hospitals, etc).

Comments & Issues Raised:

TF members raised a number of different questions for Vanessa that included the following:

- Possible misperception given by plans that providing language services is an unfunded mandate.
- Is there a way to show how much of that capitation rate is spent on any one service?
Response: The state does not have sufficient resources to go to that level of detail. Beyond that, capitated rates do not work that way, since it is not necessarily a one-for-one spending ratio.
- For an LEP patient, is there a way to recognize "additional services" or value?
Response: There is an appropriate mechanism for administrative component which is delivery intensive. CMS has a checklist that includes specific items that need to be included, which is a traditional health services.
- Reimbursement of cost – rates have been frozen for five years, have eaten away at reserves, and some plans are reporting losses. How do we address an additional cost?
Response: The change in capitation may help them get out of that plan, including a contribution amount.
- Is there a standardized system for reporting?
Response: Depends on the type of information being reported. It is a system that is not perfect, on utilization side.

Vanessa completed the discussed. Co-Chairs thanked her for her presentation and advised that they might be in continued contact with her. TF members raised the issue of whether the entire TF will be making the final determination on the MC MC issue. Lupe advised TF members that the Delivery WG will be addressing and working on the issue.

V. Next Steps:

Meeting adjourned at 3:10 p.m.

TF members are advised that there are two remaining in-person TF meeting (please see dates below). Additionally, the first draft of the report is due on September 11th.

Upcoming In-Person Task Force Meetings:

- Monday, October 15, 2007
- Monday, December 10, 2007

(Please note: All meetings begin at 10:00 a.m. and end at 4:00 p.m.)