

Medi-Cal Language Access Services Task Force
 December 10, 2007
 Meeting Notes

Attending: Lupe Alonzo Diaz, Olmedo Correa, Sarah Reed, Linda Okahara, Peggy Wheeler, Marty Martinez, Miya Iwataki, Kristin Curran, Wendy Jameson, Don Schinske, Yolanda Vera, Monica Blanco, Lisa Folberg, Doreena Wong, Elia Gallardo, Vivian Huang, Tahira Bazile, Rachel Guerrero, Marguerite Ro, Arnet Bennett, Paul Simms, Tom Riley, Ignatius Bau, Terri Thorfinnson, David Nakashima, Veronica Montoya,

I. Welcome and Introduction

Lupe Alonzo Diaz and Olmedo Correa asked attending members and guests to introduce themselves. Dave reviewed the various issues that Steering Committee (SC) members had brainstormed and the decision chart. He identified that certain issues are on today’s agenda and other issues (identified in green) are issues that may not be discussed today, based on the agenda.

Decision(s) to be made:	Type:	Issues	Next steps:
Providers Opting out of certification	Y / N	Impact on FQHCs	
Provider responsibilities (Compliance & Monitoring)	Memo discussion		
Revised Fee-for-Service	Memo discuss		
Hospital specific broker	Y/N	Broker(s)/region	
Managed Care (will we, how?)	Y/N	How will they be reimbursed?	
Admin vs. covered	CMS discussion		
Translation	Y/N	How?	
Mental health	Y/N	discussion	

Task Force members discussed how changes can be made to the report. Lupe advised TF members that significant changes being made should be forwarded to the Steering Committee (SC) and SC members can look at the different issues that need to be made. Additionally, TF members discussed whether it would be feasible to create or develop a matrix of questions and answers. Other TF members discussed “detail” questions where the discussion of the smaller issues will be determined,

that may not necessarily be appropriate to discuss at the larger TF meeting. Members discussed whether the small group meetings can review the questions on details.

Issues that were raised:

- What modes worked for what types of interpreters; had determined that – would recommend in our report that a body would be created in order to look at various “tiers” that needed specific type of interpreter for specific types of interpretation
- Is there going to be some type of requirement? Most folks – important to have flexibility, which is what is appealing in developing those recommendations. Fundamental questions: is there a requirement or guidelines for recommendation. Dave reiterated that a recommendation has been made.
- Concerns around core competency around interpretation
- What does accreditation mean?

Members also discussed other process questions related to the structure of the TF, including the issue of consensus. Dave moved the group to try and move the TF forward. Elia suggested that we should just move forward and will need to check in with their own membership. Members suggested that perhaps a “footnote” would be added in the report in order to determine differences in where the areas would be. Dave recapped that, in spirit, we should work in consensus and work toward a consensus-based document. Dave asked TF members, as a reasonable course of action, based on some assumptions, wanted to be sure that we had agreement. Members echoed agreement.

Additionally, TF members discussed “sign-on” to the report and debated the possibility of using “opt-outs” in the context of specific items. Members raised the concern of possibly weakening the “consensus” value of the report. Members commented that each TF member should be held responsible for raising their issues and for weighing in, based on the needs of their constituencies. Members discussed the need for continued advocacy with a focus on ‘next steps’ and debated the possibility of locking ourselves in an impossible situation with the suggestion that we not use any ‘opt-out’ feature unless absolutely necessary. Members generally agreed, that, if we come to a point where we cannot move, we will move toward the safety valve.

II. Break-Out Discussion:

(Break-Out Sessions have been changed to larger group discussion)

A. Providers Opting out of Certification (Elia Gallardo)

Elia suggested that an additional one-pager be reviewed and members agreed. Lupe advised that members had two minutes to review. Members, utilizing the cards system, as used in the past, would review each of the two issues.

(Please note: During the June and August in-person TF meeting, the TF facilitator, David Nakashima provided colored index cards representing the following in order to demonstrate whether an issue had consensus or not. The same method has continued to be used:

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

Initial Survey:

David asked members, based on the language provided and reviewed by Elia, whether there was initial agreement on the issue. Several TF members identified some concern indicated through the

use of yellow cards. Based on the feedback, David asked TF members to provide feedback on the decision. Members raised the following issues with feedback provided by Elia based on her written suggestions.

Any comments raised:

- Process – would need to be talked to through E & I, based on actual degree or hours. Technically speaking, may not be clear that this can actually be done.
- Issue of existing systems and overall compatibility. Many providers already have existing internal ‘systems’ and would want this to overlap.
- Would want to ensure certification or some other type of training tied to accreditation.
- Continued reservation on issue of certification.
- With certification, there are significant details that need to be determined, therefore the state will need to have this discussion. At that point, QAB should work with DHCS.
- Is there a way to amend this and add a ‘quality’ statement. Elia stated that they would work to ensure that they have ‘qualified’ interpreters, with the adoption of a new state system possibly helping.

Decision:

David queried the group to determine support for this decision. TF members were supportive of this decision with additional suggestions made to the language and the way in which it was drafted.

B. Provider Responsibility section, Monitoring & Complaints (Marguerite Ro)

Marguerite advised TF members that a phone conference call was held on Friday that negotiated different pieces of one-page recommendation, particularly on the issue of provider responsibilities. She provided a review of the one-page document (see: one-page handout).

Initial Survey:

David asked members, based on the language provided and reviewed by Marguerite, whether there was initial agreement on the issue. TF members identified minor concern indicated through the use of yellow cards. Based on the feedback, David asked TF members to provide feedback on the decision.

Questions raised for the topic:

Members asked whether there was a reason that the one-pager state ‘strongly encouraged’ versus should. Marguerite advised that this specific language was the best that we could arrive to. Marguerite advised that the language included was based on the negotiations made on the previous calls.

- CMS’ concern was the audit trail and reimbursing providers. We need to consider elements necessary related to the audit trail and reimbursement of providers.
- Members advised that the Medi-Cal card should record the language of preference. At least on program side, it would provide a method to track request. Marguerite advised, perhaps not at an individual level, but on a systems method, how languages are being provided.
- Complaint line should also be in multiple languages. Some member raised questions related to why language needs would be recorded instead of preference. Members discussed the preference that the language be included on the card, with the addition that the provider verify and that providers also support knowing the patient’s language.

Members discussed whether the provider should be the party to ask Medi-Cal beneficiaries for the language, and clarified that the language says ‘should’ instead of ‘must’ ask. Members discussed the ability on the providers’ part to require this, since it might be viewed as a change in standard of practice and could potentially create an unnecessary issue of liability. Members suggested that there may be a different method to establish an audit trail, including other methods to both verify and validate. Members were reminded that we are recommending two systems 1) doctors going through broker and 2) instances in where the doctor will bill. Members continued to discuss and those on the phone call advised TF members that many of these issues were already discussed and negotiated via the earlier phone call. Marguerite Ro, who facilitated that phone call, advised members that many of the points presented were reached through both discussion and consensus.

For minor edits, members asked who the small edits should go to with the added suggested that the actual requirements should be in the appendix. Members were advised that Elia should receive the information.

The group’s facilitator, Dave Nakashima, advised that he would like to see three points listed on this piece and then advised that we could go back and review additional pieces to this discussion. Lupe summarized the group’s discussion and advised that there appears to be consensus around items #1, 2 and 3 with some flags around item #2. The only conversation with CMS is that the new code would be tied to a medical service. She advised that a specific conversation has not been had. She advised that we capture issue on CMS side. As a result, this issue may need to be reviewed by CMS.

Dave reminded TF members that we had only previously discussed the three items and asked if there were other issues that should be added to the list:

Other issues suggested by the list:

- Training – providers should provide training
- Quality monitoring
- Certification

Training: Members had questions regarding the decision memo. Members were advised that the federal guidance states that staff should be trained and added that this would be an area that can be strengthened and the state has authority to do that. The federal direction lacks detail. Lupe asked members, if the guidance were to be added, whether it would be sufficient and was advised that additional guidance should be given to providers. Dave recapped by stating that #1 was sufficient without needed a separate #4 on the issue of training. Members agreed.

Members discussed whether the discussion around training was an issue of whether the federal law should simply be restated in the report or whether additional information should be included and possibly restated on the issue of determining a compliant plan. Some members expressed reluctance around any possible interpretation and emphasized a preference to simply restate existing law in lieu of any interpretation which could be perceived as a broadening of existing requirements. Member agreed, that for the purposes of the report, only a restating of existing would occur.

Decision:

David queried the group to determine support for this decision. He asked if there was agreement to not interpret existing requirements but add a segment on compliance. Task Force member agreed.

Quality monitoring: Under the issue of quality monitoring, TF members continued to discuss who should be responsible for use of the brokers in ensuring that services were actually being provided. Members additionally discussed a minimum level of services that should be ‘screened for’. Members raised the concern that not all providers or entities would be using the broker model and raised questions on how they additionally would ensure that services were actually being provided. Olmedo Correa, co-chair, advised that there would be monitoring by the states and that patients could continue to use an 800 phone number, particularly if they are not happy with the services provided by the doctor. While he recognized that this may not capture a 100% of the issue, it might be a significant piece.

Initial survey:

Dave asked if Lupe can recap whether quality monitoring be included in the decision memo, beyond the five issues and asked whether there would be support for the issue. Several members indicated that they would not be supportive.

Decision:

The group opted to not continue that conversation and would not include a #4 that says anything about quality monitoring by provider beyond the five components as it stands under federal law.

TF members also agreed that we would include 5 components with addition follow up with CMS on #2. While there is no agreement to language, CMS would be asked whether this is sufficient for auditing. If not, the language is due to come back to the TF.

C. Revised Fee-for-Service (Vivian Huang)

Vivian advised that some time had occurred between the last discussion around the broker model. She advised that some discussion and updates have taken place since then that necessitated re-review of the decision memo, particularly under the hospital component. She advised that only some components had been modified and that the recommendation was largely based on previous discussions held by the TF. She advised that we did confirm that entities that had staff, could apply to be a regional broker. Under this description, it is still to be determined whether hospitals can remain as hospitals-only.

Related to the one-pager, she advised that there might be some questions around billing. For example, there are a lot of providers that use the billing code method. She advised that we could build on existing system. Currently, Medi-Cal has six billing codes. She advised that we could add additional billing codes and providers could add additional billing code. She advised that particular providers, such as hospitals and FQHCs should be added, if they were pursuing reimbursement. She hoped that this would be an additional clarification.

Initial Survey:

David asked members, based on the language provided, whether there was initial agreement on the issue. Several TF members identified some concern indicated through the use of yellow cards. Based on the feedback, David asked TF members to provide feedback on the decision. Members raised the following issues:

Issues raised:

Members asked whether they would be deciding on fee-for-service and Vivian advised TF members that this would be deciding on fee-for-service. Vivian advised members that the list is not exhaustive and suggested that the TF should not drill down to such detail. Members advised that they would like to see 'broader' language around the pieces. Olmedo advised that we do not want to get into all of the specifics, since the TF may not have that level of expertise and suggested that perhaps there may be another workgroup that the director assemble.

Additionally, members asked for more information in billing and whether it would be based on 15-minute increments versus an hour. Vivian advised that it is currently not based on time, but similar based on "moderate" versus "complex" case and so forth. This is a difference that needs to be acknowledged. Lupe advised that we do have a different rate structure.

Decision:

David queried the group to determine support for this decision. Members indicated support.

D. Hospital Specific Broker (Wendy Jameson)

Wendy advised that we should continue to build on what is working well, particularly as part of the network while minimizing administrative burden. She suggested that, according to the one-page recommendations, hospitals should be able to either 1) direct billing or in instances where there are two hospitals 2) they serve as a broker. She asked that they be able to do both, if needed.

In terms of serving as a broker, she suggested that there should be minor exceptions: 1) should not require that everyone within the system should be served and 2) hospital pool should serve as a network pool and would not be asked to be part of a language agency particularly since many are already "at capacity". TF member Peggy Wheeler, advised that it is the flexibility that works best.

Initial Survey:

David asked members, based on the language provided, whether there was initial agreement on the issue. Several TF members identified some concern indicated through the use of yellow cards. Based on the feedback, David asked TF members to provide feedback on the decision. Members raised the following issues.

Issues and comments raised:

Members asked several clarification questions regarding who can be broker and the use of different types of brokers. Members expressed an interest in having this as an option for individual membership.

Members raised questions on why hospitals would need a separate process instead of applying to be a regional broker. Wendy advised that that the local one may seek that process while others may need alternative options, largely due to the issue of capacity. Members also discussed whether an alternative name could be utilized in order to minimize confusion. Members advised that, in the state of Washington, there are dedicated brokers through regions. Members discussed the possibility of identifying this as a network-specific broker.

Dave asked members to recap on what the status of the discussion was. Members expressed some concern about having multiple brokers, largely due to the economies of scale issue as well as the possibility of little-to-no interest from entities becoming brokers. Members discussed the possibility of having the state review the ‘economies of scale’ issue to determine instances where a broker should or would need to be established as well as other issues related to overlapping services and location.

Members raised additional questions related to the recommendation and how it would be reflected in the report. Specifically, questions were raised on how this would be phrased and where it is located within the report. Members discussed the particular needs of hospitals related to the 48-hour notice and emergency status that would not work under the existing regional broker system. Members discussed whether hospitals could continue providing these services while allowing for additional flexibility. Members discussed whether this should be pulled out of other recommendations or whether there should be direct billing. Wendy advised that a choice would have to be there.

Other comments:

- Given the state’s size, in relation to Washington’s size, the broker system should consider having more than broker per region.
- From state’s standpoint, no matter what the product is for the beneficiary, it should be considered on the basis of volume.
- Members added, that like managed care, they should be able to serve different regions while ensuring that there is enough coverage on what’s left over in multiple contracts allowing for the diversity of options.
- Members added that there are certain parts of CA (rural, small), that may still need carve-outs for those rural areas, particularly if there is a lack of brokers for that region.
- Members advised that there should be some language around barriers of access due to lack of economies of scale and advised that there needs to be some responsibility for those regions not receiving care. Members asked if there could be a “premium” given to those areas that aren’t covered.
- Members clarified that the focus should be on ‘network’. The state should look at the issues of volume, quality, what people are offering and would make a decision made on that.
- Members discussed the need for an ‘exclusive’ network and discussed the alternate use of either building incentives or allowing carve-outs. Members advised that the focus should be on determining a solution or solutions that are most economically viable, regardless of the configuration.
- Members discussed that final geographic responsibility should be determined by the state in order to ensure that someone somewhere can provide services.
- Members continued to express an interest in allowing non-hospitals to additionally access the systems.
- Member discusses the issue of diffuse languages and whether these would need to covered through an alternative manner.

Members discussed the agreement to have more than one broker per region and the possibility of having the state review the issue. Members discussed having a Provider-Network billing. Members discussed how this would practically work. Members discussed allowing flexibility while limiting the total number of those that provide brokers. Wendy advised that there could be some

modifications given to provide parameters, including not serving others, having their own dedicated staff and not having staff that participate in language agencies.

Initial Survey:

David asked members, based on the language provided, whether there was initial agreement on the issue. Several TF members identified some concern indicated through the use of yellow cards. Based on the feedback, David asked TF members to provide feedback on the decision.

Decision:

David queried the group to determine support for this decision. Members indicated that they wanted to see the language.

E. Managed Care (Lupe Alonzo Diaz):

Lupe advised that, while we have spent a significant amount of time on FFS, this still looks at how managed care plans will access and how they get reimbursed. To date, there are two options: 1) all plans should have some existing piece in place and 2) around use of brokers and whether plans would be able to access broker services.

Around the questions on existing infrastructure, there are the following questions:

- If plans can access through existing infrastructure, is there a change in how they are reimbursed?
- Also, around compliance and whether that means increased compliance on the monitoring side.
- On the broker side, it is whether or not managed care will be included.

Olmedo additionally provided the following update regarding outstanding questions from the previous meeting:

1. How does DHCS monitor health plans?

First, goes by Title 22 and from Title 22 the state went ahead and drafted the existing contract with 23 health plans. Whenever dealing with plans, the state goes by contracts and the requirements under the contracts.

In addition to the contract language, the state also sends out an ‘All Plan Letter’ or Policy Letters that can add provisions that build on contract language. This does not deal with changes but rather gives clarification. The division also sends translation of materials to the plans and DHCS is heavily involved and they know what is being given to individual members.

There is also a “Member Rights” that must monitor plans at least once a year, including interpretive unit in addition to a Medical Monitoring Unit that does site review, as part of the contract. The department does not conduct audits over a 100% universe but does conduct random checks. Additionally, from a formal standpoint, audits and investigations coordinates with DMHC which is done every three years, though they can go in with more frequency to conduct Facility Site Review. Direct contracts with Medi-Cal does allow them to go in and do review without notice.

Additionally, there is an Ombudsmen office that currently provides services. While dedicated initially to managed care, this now includes services to fee-for-service (FFS), particularly since FFS

does not have any similar or like service. For language-related questions, Medi-Cal beneficiaries are able to utilize ombudsmen services.

2. What are the threshold languages and how are the languages determined?

List given. Based on the county - 3,000 per county.

3. What is the utilization of language services by LEPs?

The department, back in September, for Medi-Cal FFS, provided data counts. In managed care, 55% of the language spoken by Medi-Cal managed care is English with another 35% related to Spanish-speaking with the other 10% making up another language. Under fee-for-service the languages spoken are: 46% English, 40% Spanish, 14% is other. In order to get updated information, a survey went out to plans. A majority of the plans, apart from the AT&T telephone, the majority hire bilingual staff in their threshold languages. They take that into consideration and additionally use the language line and discourage the use of family and friends.

4. How do plans ensure that providers are providing language services?

A majority of plans monitor this through their grievance process, either a compliance officer or office, an 800 phone number, or are made aware of the state's Ombudsmen's office. Plans are generally asked to not only indicate the services provided, but are asked to demonstrate the provision of these services. Some of the provider conduct workshops and actually do audits of report

Questions raised:

If the provider had to secure services outside of their staff, how do they pay for this? And is it part of their capitated rates? Olmedo advised that the department contracts with the plans and the plans sub-contract with the providers. The department requires those health plans from their networks. If you provide those services, there might be a cost and that would be between the plan and the state. In many cases, there is additionally the 800 number. The state is not involved in that discussion.

- Is the rate assuming that that rate is included in the capitated rate? Would you pay more for those LEPs? Would there be a state role in negotiating those rates on a per-member, per month basis? Olmedo advised that this is another issue and they already take this into account in administrative line item. There is no specific line-item and is included with the administrative line-item. This includes the interpretive services.
- Now that we have the background, what are we doing with that? Dave asked the group to consider what we are trying to do with this information.
- Is there a way to look at these 23 health plans and is there a way to determine a rate for LEP, particularly since services have already been provided without use of federal funds? Members acknowledged that this might be more difficult on the managed care side and easier for fee-for-service where services are not as clearly provided. Members acknowledged that this might be related to why other states do not include managed care plans in their reimbursement systems.

Other issues raised:

- Members acknowledged that we need adequate enforcement. If the provider, delegated providers don't see something tangible, even with higher quality without enforcement, it doesn't mean anything. We should include here somewhere, that there is a tension between the division of financial responsibility. There needs to be a clarification that there is a downstream. Something explicit needs to be included.

- Plans should be used to documenting and have a year of specific research. Something needs to be fixed, but there isn't enough information.
- Members identified that we can't expect plans to tell us the utilization rates, particularly if providers aren't telling the plans this information. If this was a discreet item that needed negotiation, until you have this, you have to require the tracking on how much is spent and later, they can determine whether this can be backed out and whether this is paid.
- As a committee, many of the issues mentioned, also exist in mental health. As a committee, need to write recommendation as part of final recommendation. We're not going to solve these problems. Have no idea, funding is bundled, so we need to audit and include in recommendation.

Dave asked if some recommendations can be included in Managed Care, particularly if it is unclear what the state receives from plans in terms of services and the fact that they are not supportive of any changes made to capitated rates in lieu of developing another system with these funds.

Lupe advised that more information needs to be shared. Members advised that without it, this TF might box itself in to a recommendation that will not be feasible. Lupe advised that perhaps in early January, there could be conference call to finalize the recommendations around managed care.

Decision:

David queried the group to determine support for this decision. Members indicated support.

F. Certification (Marguerite Ro)

Marguerite provided an overview of the one-pager that provide different language around Medi-Cal qualified instead of 'certified'. The process is the same for developing the process, except that "Certification" is generally a loaded term.

Initial Survey:

David asked members, based on the language provided, whether there was initial agreement on the issue. Several TF members identified some concern indicated through the use of yellow cards. Based on the feedback, David asked TF members to provide feedback on the decision.

Issues raised:

Marty Martinez, chair of the Quality & Standards Workgroup advised that this issue was explored at the committee level. He does understand the issue and understands that the Medi-Cal does certify. Marty advised that various interpreters have been participating and the TF has been adopted recommendations under certification. Marty advised that there might be some way of working on the issue and there may be a way that uses both versions. Various members weighed in on the certification as a difficult issue. For others, certification is positive related to the issue 'qualified' individuals. Members discussed the possibility of using another term. Members also discussed the fundamental point as developing training standards, platform of standards, having a test at the end of the training program for the sake of receiving Medi-Cal. Members discussed the difficulty of setting the bar too high or too low as well as whether the state should decide the issue.

Lupe advised that there seemed to be consensus around language adoption. The process that remains is who still has to be discussed. In other words, who is Medi-Cal qualified? The state is

setting up a system through the RFP process that includes testing, and certifying. TF members discussed how to proceed on finalizing this issue.

Decision: Marguerite advised that we have consensus around not using “Certification”. Instead, the committee can have another conversation around the name that is not opting to have Medi-Cal look at this.

III. Next Steps:

Co-chairs advised TF members that the next meeting would be back at USC Sacramento Capital Center at 1800 I Street on **Wednesday, January 23, 2008**. The meeting starts at 9:00 a.m. and is due to go until 5:00 p.m. A group photo will be taken at the next meeting.

Issues to be discussed at the next in-person Task Force meeting:

1. Sequencing (what happens when)
2. Pilot project