

Medi-Cal Language Access Services Task Force  
December 13 & 14, 2006  
Meeting Notes

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**Present:**

Task Force Members:

Lupe Alonzo-Diaz, Vanessa Baird, Qiana Charles, Elia Gallardo, Rachel Guerrero, Vivian Huang, Miya Iwataki, Krystal Lee (Alternate), Marty Martinez, Debra Mullins (Alternate), Edmund Corrolan (Alternate), Carolyn Pierson, Tom Riley, Bob Sands, Don Schinske, Paul Simms (Alternate), Ho Tran, Peggy Wheeler, Irv White, Doreena Wong

Guests:

Sandra Shewry, DHS, Eva\_, CMA, Uzoma \_\_\_\_\_, CBHN, Veronika Geranimo, APALC, Dean Lee, OCR, Veronica Montoya, LCHC, Wendy Jamison, Sandra Perez, Office of Patient Advocate

Facilitator: Laurin Mayeno

Note: Decisions made by the group are highlighted in **bold**. Also note that a list of follow-up items was generated throughout the meeting. This list is included at the end of these minutes.

I. Welcome

Sandra Shewry, Director, DHS, welcomed the groups. She mentioned that the SB1405 was withdrawn based on the commitment of the department to doing the work around Medi-Cal language access. She also stated that she is committed to follow-through and shared her hope for the success of the Task Force.

II. Introduction & Task Force Charge

Co-chairs, Carolyn Pierson and Lupe Alonzo-Diaz provided information on background and purpose of the meeting and the charge of the group. They recognized the role of advocacy organizations in SB1405. This group represents different constituencies and is an opportunity to do something proactive to address language access utilizing reimbursement available from the federal government. .

Meeting Objectives:

- Get to know each other
- Establish a framework for the process
- Identify questions to address

III. Introduction of Members/Participant - Participants introduced themselves.

IV. Objectives

Laurin Mayeno reviewed the objectives and agenda for the meeting. **The following guidelines for communication were discussed and adopted by consensus:**

- **Listen with respect**
- **All voices heard**
- **Okay to ask questions**
- **Focus on greater good**
- **Clarify “lingo”**
- **Step up/step back**

- Stay present, put cell phones on vibrate, etc.
- Assume good intent

V. Background on Language Access

Carolyn Pierson provided background on how the Medi-Cal system works to provide a common language for the group.

VI. Responsibilities, Roles & Process

The group reviewed two key documents that provide the framework for the Task Force: “Medi-Cal Language Access Services Taskforce” and “Participation Agreement”.

A. Participation Agreement

**The group agreed, by consensus, to the participation agreement, with the following revisions:**

- **Attendance (Section IV) Participants will make every effort to be at 100% of taskforce meetings in person. If people cannot attend in person, limited exceptions will be made and the option to participate by conference call will be provided. The group recognizes the disproportionate burden to those who have to travel farther.**
- **Participation (Section IV) – add good cause clause**
- **Responsibilities (Section V): “to the best of their ability” inserted in the opening sentence.**

B. Decision-making

**The group agreed, by consensus, to the decision-making structure outlined in the document, with the following revisions:**

- **In some cases, TF members require organizational approval before participating in decisions.**
- **Voting in absentia when an issue has already been discussed (will be allowed only in exceptional situations)**

C. Objectives, Outcomes and Charge

The group did not have any changes to objectives and outcomes outlined under Task Force Charge. The group discussed the parameters of the Task Force in order to clarify what is and isn’t within its charge. The following table summarizes key points:

Responsibility: Yes/No	
Yes	No
<ul style="list-style-type: none"> <li>• Follow-up and technical assistance after report</li> <li>• Language access of eligibility (need to prioritize)?</li> <li>• <b>Look at interpretation and translation services at point of accessing Medi-Cal services (priority take on first)</b></li> <li>• Compensation leadership</li> <li>• Cultural competency in context, standards and quality for interpretation and translation</li> <li>• Training certification (recommend)</li> <li>• Outreach to eligible beneficiaries; how to access/find services</li> <li>• Data collection (what, how to analyze)</li> <li>• What Medi-Cal now pays for and what else needs to be covered (state, local, federal responsibility)</li> </ul>	<ul style="list-style-type: none"> <li>• Eligibility system?</li> <li>• People who don’t get through eligibility process</li> </ul>

D. Technical Advisory Group (TAC)

A suggestion was made to include audits and investigations in the TAC.

#### D. Benchmarks – Deadlines

The group identified the following benchmarks and deadlines to serve as a guide for the work.

Dec 2006	
Jan 2007	
Feb 2007	Taskforce meeting
Mar 2007	
Apr 2007	Taskforce meeting
May 2007	
Jun 2007	Taskforce meeting – draft concept
Jul 2007	
Aug 2007	Taskforce meeting – draft one, including \$ implications
Sep 2007	
Oct 2007	Taskforce meeting
Nov 2007	
Dec 2007	Taskforce meeting – Final Report

#### V. Force Field Analysis

The group identified the “driving forces” and “restraining forces” that impact its charge (see Attachment 1). They then highlighted (see items in bold) those items that the Task Force can impact through its work. This exercise was used to inform the Task Force in identifying questions/issues to address in its work.

#### VI. Steering Committee Role

The group discussed the commitment and qualifications of the steering committee as follows:

- Meetings by conference call
- Frequency to be determined

##### Steering Committee Qualifications

- Time commitment
- Represent their caucus not just their organization
- Elicit input and think about others in your constituency

#### VII. Caucus Meetings and Steering Committee Elections

Task Force members met in caucuses according to constituency group. **Each group identified one or two steering committee members.** In addition to the two co-chairs, these members comprise the steering committee as follows:

**Providers: Elia Gallardo and Don Schincke**

**Government: Carolyn Pierson and Miya Iwataki (Quiana as the alternate)**

**Consumers: Lupe Alonzo-Diaz and Marty Martinez**

#### VIII. Models for the provision of language services in other states

Veronica Montoya presented information about different models of language access services in other states. The group discussed these models, as follows:

- Rate for interpreters sometimes higher than providers
- Washington has problem keeping funds to pay for program
- How they qualify beneficiaries - some using interpreters when not needed, fraud. This is why Washington went broke.
- People lose second language in crisis.
- In some setting you can have just as high quality with telephone. (Question assumption that face-to-face always preferred.)
- Quality – training requirements and testing. No accepted amount of training required – minimum of 40 hours. Some have a higher level.
- Assessment of what is learned and training and fluency level, literacy level.
- Sight translation requires a different set of skills (pill bottle/forms, reading and saying)
- Is there a particular model that accommodates most languages? Washington has the most. Market demand issue if few people speak a particular language.
- Do any states have model interpreter I, II different levels required? (Kaiser and Sutter have Level I – basic appointments, etc., Level II medical)
- There are many resources available that have information on these and other models: TCE Report, “Straight Talk”
- Public Hospitals use internal staff system, sharing between hospitals.

#### IX. Identify Large Questions to Answer

The following were used to frame the identification of question for the task force to address:

Models in Other States: what do we need to know for a model or hybrid of models from other states to work in California?

California model: what do we need to know about: cost/financing; delivery system; quality and standards; oversight and accountability?

The questions were then clustered as follows:

#### Cost/Finance

- FFS v. Managed Care and Administrative v. Covered
  - Administrative Burden?
  - Administrative or covered expense?
  - Is there a federal waiver to enhance language access services?
  - FFS v. Managed Care, Administrative Cost or Service Expense?
  - How do states include interpreter reimbursement in their managed care/capitated rates?
- Funding Models
  - What are the MCS reimbursement requirements?
  - Can we use inter-govt agreements/transfers as part of state match like other states (ie Washington)?
  - Is the \$ rate enough?
  - What are the funding models that other states use?
  - Do other states provide GF to draw down federal funds?
- Provider Reimbursement
  - What would it take (political will, process, time, etc.) for CA to establish a separate billing code for language services?

- How will providers (interpreters and bilingual clinicians) be reimbursed? Billing code in FFS? Enhanced rate in Managed Care?
- How have other states implemented billing code tech and strategies?

### Delivery Systems

- Infrastructure – workforce, systems
  - Experience with interpreter/translator workforce? Are there enough?
  - How are more interpreters brought into the system?
  - To what extent our diverse language available?
- Types of Services/What is Reimbursed?
  - Establishing at least 2 levels of interpreters (ie basic appointments vis a vis medical terminology)
  - Should interpreters be reimbursed for no-shows, travel time or waiting time? Should bilingual staff/providers be included in reimbursement system?
  - How can the model work for remote or face to face interpreting?
  - What types of services will be covered? Interpretation? Translation? Telemedicine interpretation?
- Lessons Learned Other States
  - Why a particular state picked a certain model, delivery system to address?
  - Actual experience of state with their model
  - How effective? Which model? Language agency/broker? Reimburse providers? Reimburse interpreters? Telephone line?
  - How were agreements with public hospitals and health districts structured by Washington model?
- Existing Models for Reimbursement
  - Should bilingual providers be reimbursed?
  - Can qualified bilingual/staff interpreters be covered? Issues...
  - What type of delivery system – bilingual staff v. contracting out?
  - Can large health care systems (Kaiser/Sutter) use their own language delivery systems? Can they be brokers for themselves?
  - Is there a model that works with providers hiring interpreters and providers accessing interpreters from outside?
  - Existing network?
  - The provider should include issues for mental health language access?
- Safety Net
  - Can we develop clear policy for FQHC and DSH hospitals in the CA language access program?

### Quality and Standards

- Standards for Interpreters
  - Should quality standards focus on a floor to seek broadest participation?
  - How does the state ensure competency of interpreter? Does certification work (pros/cons)? Who certifies?
  - What are the best training programs for HCIs? Does managed care cover it?
  - Patient satisfaction
- Assessment to Meet Standards
  - Data collected” required? Manual or electronic? How often?
  - How is quality assessed? Does the process work?
  - How to ensure quality with such low Medi-Cal rates? Way to call it a partial payment?
- Other
  - What process ensures timely provision of interpreters?

### Oversight and Accountability

- What's required?
  - Was a law passed to create a language program identifying a governing body and funding?
- Who's responsible?
  - Can public/patient conduct monitor and/or enforce rights?
  - What agency is charged with oversight?
- How is it done?
  - How are quality language services ensured – auditing, etc.?
  - How do other states create oversight and enforcement?
  - Fraud prevention

X. Establishment of Work Groups

**Work Group Chair Responsibilities were discussed and agreed upon by consensus:**

- Convene meetings
- Set agendas
- Host calls/meetings
- Make sure decisions are documented (can delegate)
- Written report to taskforce (before each meeting), Vero will provide format

The following individuals were selected to serve on the workgroups and act as chairs for these work groups. Taskforce members not present – still need to be added. A distinction was made between workgroup members and people who will serve as resources to the workgroups.

Work Groups	Members	Resources
Delivery Systems	Chair: Vivian/Elia Tom, Elia, Don, Miya, Rachel, Irv, Doreena, Vivian, Vero	Wendy, Irv, Qiana, Vanesa, Marty
Cost/Finances	Chair: Irv/Lupe Don, Irv, Qiana, Vanesa/Debra	Bob, Doreena
Quality and Standards	Chair: Marty Don, Tom, Carolyn, Marty, Bob, Lupe	Miya, Vivian
Oversight and Accountability	Chair: TBD; Paul – interim, (Carolyn – backup) Bob, Marty	Doreena

X. How to Start Process

The group agreed by consensus to the following:

**Delivery System (Start with this)**

- Start with what providers do now
- Look at existing models
- Other bullets are discussion items
- Workgroups start to gather information and share what is relevant to delivery system in first discussion

- Use existing recommendations and build off of them (public hospital, family physicians, Sutter, CMA, dentists, etc.)
  - Doesn't incorporate government or consumer perspective and mental health

**Identify guiding principles/values. Draft based on work that has already been done. Quality and Standards workgroup will be developing these principles. Send input to Marty Martinez.**

XI. Discussion about Parameters, Focus and Strategy

An issue was raised about what part of the system the task force should start with. This was based on a concern that the entire system would be too big to take on. There was also a concern about being inclusive of Medi-Cal beneficiaries and different types of service needs. This issues was discussed as follows:

What is the box we start with? End with?

- FFS and Mental Health carve out
- Managed care (already has contract language) some plans have systems in place
- Equal depth and quality: consider different needs of different health services/may need to prioritize w/in FFS
- State walk us through how to access \$ for int. in Managed Care. No specific adjustment exists.
- Consider impact of universal access legislation.
- There is nothing we'd have in place for FFS that we couldn't offer to managed care (but not vice versa)
- Managed care supposed to be as good or better than FFS
- FFS prioritize and expand to Managed Care
- Provider may be in both FFS and Managed Care
- Don't assume all in FFS apply to Managed Care
- Focus on beneficiaries
- Need health plan person on different workgroups (Martha)
- Need access to state managed care person (Vanessa)

**Consensus was reached on the following:**

- **Make sure both FFS and Managed Care got equal quality and attention in report**
- **People interested in increased participation in delivery system group**
- **If start with one, not a big lag time to next**

CHIA and Academy available as resources

XII. Follow-up Tasks

The follow-up list, generated during the meeting was reviewed. Actions for each item were identified (see left hand column).

work plan	Data Issue – need outcomes, impact information in FFS for public dialogue
✓	Eligibility process – who hasn't gotten in, not just existing beneficiaries
Workgroup, Safety net work group?	FQHC – can include pay differential for bilingual staff in cost basis? Can include written translation? yes
Workgroup	Different agreements providers sign (clinics and individual providers), what obligations? Is language strong enough?
Workgroup	Mental health providers payment for mental health services; difficulties in paying for language services if FFS – not specialty mental health carve out, state DMH

Out of Scope; general rec.	Non-English speaking seek services in county w/o specialty providers taking new Medi-Cal; Medi-Cal mental health was supposed to solve this
TAC	Drug and alcohol representative on taskforce
Workgroup	Data – not possible to compare FFS and Medi-Cal data by LEP/non-LEP? Problems with data – how primary language is determined.
Strategy – initial discussion, subgroup	Parameters – Interim plan? Start with Medi-Cal FFS Prioritize and create links (with rest of system)
Focus of group	Mechanism for drawing down federal funds
	Framing/strategy: not optional – how to fund – preventive (lawsuit) risk management
	Resources/posting on website

#### Additional Next Steps

- Send out roster with committee members by next week and next steps
- Notes – raw notes to taskforce by 12-22-2006
- Send web link