MEDICAID MANAGED CARE AND CULTURAL DIVERSITY IN CALIFORNIA

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EXECUTIVE SUMMARY

This study examines California's implementation of a strategy to require managed care plans to provide appropriate services to the state's highly diverse Medicaid population. Like many other states, California has shifted a large proportion of its Medicaid-insured population into managed care plans over the past several years. By the close of 1998, more than 3 million Medi-Cal (the state's Medicaid program) beneficiaries will likely be enrolled in commercially or county-operated health plans. Approximately one-third of beneficiaries in the state's 12 counties with mandatory Medicaid managed care enrollment in 1997 indicated a language other than English as their primary language, making California's the largest Hispanic and Asian American Medicaid population in the United States.

Many state Medicaid programs have included provisions in their contracts with health plans requiring the delivery of "culturally competent" services to patients. Rather than relying upon the traditional tool of regulation, California decided to create detailed health plan contract requirements to ensure culturally appropriate care. The state also hoped to stimulate competition among commercial managed care plans by including ratings of plans' culturally competent service requirements in the competitive bidding process. Among the contract provisions required by the state are:

- 24-hour access to interpreter services;
- translation of all written materials distributed to non-English-speaking members;
- defined threshold criteria for non-English-speaking populations requiring additional linguistic services;
- assessment of the linguistic capability of plan employees and interpreters;
- member needs assessments;
- development of cultural and linguistic services plans; and
- establishment of community advisory committees to assist in developing and monitoring culturally competent services.

Interviews with Medi-Cal staff, officials of private and public health plans, and providers serving the Medi-Cal managed care population reveal that California's contract requirements have had a substantial impact on health plan services and operations. Plans have hired additional staff and established member services to make access to plan services easier and more effective for non-English-speaking populations. Health plan networks have also

been expanded to include minority physicians, community health centers, public clinics, and other traditional providers of care to Medi-Cal beneficiaries. In addition, Medi-Cal requirements have created a market for vendors of services to support cultural competency, as well as a demand for bilingual workers for health plans and provider organizations. The Medi-Cal requirements have had far less impact on providers (i.e., individual and medical group practitioners), although traditional safety net providers have gained leverage in their negotiations with health plans to obtain managed care contracts.

While these indicators are encouraging, multiethnic populations served by Medi-Cal would benefit from improvements in several important areas. For example, the state could promote greater quality and efficiency in the provision of linguistic services by simplifying the process of producing and approving translations for plan materials and recommending standards of quality for interpreter services. Medi-Cal plans and providers, which have been preoccupied with the complex process of providing appropriate linguistic services, also need to proceed with addressing other cultural issues in designing member services.

If cultural competency in health services is to be measured directly in terms of patient satisfaction, health outcomes, and health status, then Medi-Cal does not yet have the information necessary to conduct these assessments. Several practical steps would promote greater accountability to the health needs of multicultural populations, including assessments of the validity of information in the system's demographic database and improvements to initial patient interviews and data gathering. The ultimate goal is to link members' race/ethnicity and linguistic group to patterns of utilization, health outcomes, and member satisfaction in Medi-Cal managed care. As California moves closer to adopting a system of risk adjustment in setting insurance premiums, further study will be needed to determine whether additional costs are involved in providing care to non-English-speaking populations.

Although the state's commercial health plans and local initiatives (locally operated health plans) have produced some promising new innovations in the provision of culturally competent services, these have gone largely unreported and unevaluated. Furthermore, experiments that have been proven effective have not been disseminated to other plans. Evaluating existing programs and providing technical assistance would further the development of specialized services for multicultural populations in California and other states.

California's experience in implementing cultural competency guidelines offers some valuable insights into the operational needs of Medicaid managed care programs throughout the nation. These include data systems capable of providing information on health care delivery to different racial and ethnic populations, systems for monitoring quality of care, and expanded training opportunities for health professionals. National accreditation programs for managed care providers should also be encouraged to include measures of cultural competence based principally on health outcomes by racial/ethnic or linguistic group.

SUMMARY OF KEY FINDINGS

The difficulties of reaching, educating, and enrolling a complex multicultural population in a managed care system that is itself new and still evolving should not be underestimated. This study examined a system with a multitude of new plan and provider services, most of which are as yet largely unevaluated. Nevertheless, several conclusions emerge from this early review.

Medi-Cal contract requirements for cultural competency have had a substantial impact on health plan services and operations.

The Medi-Cal requirements have led plans to add staff and establish training programs and services designed to make health care access easier and health care services more effective for multiethnic populations. Prior to contracting with Medi-Cal, most mainstream plans had addressed minority populations only in the context of marketing. All plan representatives reported that their cultural competency efforts are now supporting plan and provider services for non-Medi-Cal enrollees as well—suggesting that Medi-Cal's strategy was indeed seeding greater cultural competence in plan operations aimed at privately insured populations.

The key effective components of the contract requirements include:

- *Defining criteria for threshold populations.* Because of the great diversity of racial, ethnic, and linguistic groups served by Medi-Cal, plans and providers need a clear definition of the populations and service areas for which specialized services are required. Medi-Cal's threshold and concentration criteria appear to be useful toward this end.

- *Translation of plan materials.* Although the process of state approval is apparently cumbersome, it has spurred health plans to make their member services and health education materials uniformly available in languages appropriate to the needs of their members.

- *Complete access to interpreter services.* By requiring plans to provide 24-hour telephone access and establish protocols for the scheduling of interpreters when necessary, Medi-Cal has ensured a baseline availability of language services for beneficiaries.

- *Community participation in plan services development.* The establishment of community advisory committees has provided plan members with an organized framework for representing their needs and reviewing plan services. In addition, health plan staff gain insights from their direct interactions with members.

Other findings stem from health plan implementation of Medi-Cal contract requirements:

- *Development of training programs.* As plan services directors and provider organizations focus on meeting the needs of specific linguistic and cultural groups, administrators have recognized the need for more staff education, and all plans and provider organizations now have training programs. Although these programs have focused initially on linguistic needs, all individuals interviewed commented that they were developing or attempting to identify effective programs dealing with other cultural aspects of health care. This work is being supported by a growing collection of tools and instruments for assessing cultural competence.[1]

- *Use of community health workers.* Not surprisingly, some plans and providers have realized that providing education to members on an ongoing basis and managing chronic disease and prenatal care for non-English-speaking patients can be difficult and time-consuming. This in turn has led to increasing experimentation with the use of community health workers. In light of the limited contact time available between patients and clinical providers in most health care settings today, community health worker programs may offer an effective means of support for the health care management needs of all patients.

- *Use of plan surpluses.* Several of the Medi-Cal local initiatives reported plan surpluses at the end of their first year of operations. Each plan has allocated a part of its surplus to community education, risk prevention, and disease management initiatives aimed at non-English-speaking populations.

Provider networks have been expanded to include minority physicians, community health centers, public clinics, and other traditional providers of care to Medi-Cal beneficiaries.

- *Minority physicians and traditional providers.* Medi-Cal policy calls for local initiatives to include traditional providers in their managed care networks. Mainstream health plans were selected in a competitive bidding process that rated the adequacy of provider networks, including representation of traditional providers and provision of appropriate linguistic services. Mainstream plans reported that this process led them to expand their provider networks substantially. A recent study of Medicaid managed care contracting in California found that minority physicians participated at equal rates.[2]

[1] M.D. Tirado, "Tools for Monitoring Cultural Competency in Health Care," presentation to Sacramento Department of Health Services, April 1998.

[2] A. Bindman et al., "Selection and Exclusion of Primary Care Physicians by Managed Care Organizations," *Journal of the American Medical Association* 279 (March 4, 1998):675–679.

- *Public hospitals and clinics.* Public hospitals have historically been at the forefront in providing interpreter and other services for California's non-English-speaking populations. The Medi-Cal managed care expansion plan proposed the development of local initiatives largely to ensure public and community hospital participation in managed care at levels adequate for these institutions to continue to receive Medicaid disproportionate share payments. The actual effect of this requirement, however, has been to maintain the availability of multicultural services at those hospitals.

Medi-Cal requirements have created a market for vendors of services to support cultural competency and for bilingual employees in health plans and provider organizations.

Community-based organizations, in particular, have benefited from cultural competency requirements. Some have expanded their operations to include interpreter training, interpreter pools, and provider training. These services represent a new source of revenue for community organizations still uncertain of the impact of Medi-Cal managed care on their financial stability. In addition, new employment opportunities within health plans have been created for bilingual staff.

The new requirements point the way toward further reforms to improve patient satisfaction with Medicaid managed care.

While the indicators of progress described above are encouraging, there is no question that the multiethnic populations served by Medi-Cal would benefit from improvements in several other important areas. In fact, some of the problems encountered by minority populations are shared by white Anglo Medi-Cal beneficiaries and by those enrolled in private managed care. The Governor's California Managed Care Improvement Task Force, which included representatives of health plans and purchasers as well as providers and consumers, released a report in January 1998 calling for a broad set of reforms. Among them were a new state department to oversee managed care plans, standard information on health plan quality and performance for consumers, an external appeal review process, and pilot testing of risk adjustment for health plan premiums. The task force clearly saw the need to make managed care more responsive to consumers' concerns and thus laid the foundation for future legislative action.

IMPLICATIONS AND RECOMMENDATIONS

California's experience in implementing cultural competency guidelines in Medicaid managed care contracting offers some valuable insights for Medicaid managed care programs throughout the nation. States will need to work with plans and providers to resolve some key operational issues.

States could promote greater quality and efficiency in the provision of culturally competent services by implementing effective contracting guidelines.

- *Simplify the process of producing and approving translations for plan materials.* Health plans participating in Medicaid managed care frequently serve 5 to 10 separate language groups. The sheer quantity of material to be translated and approved by state agencies can introduce delays and complexities that may be avoidable. Plan and provider administrators suggest that states approve organizations and individuals for providing and reviewing translations and eliminate the requirement for subsequent state review. Doing so would minimize possible delays in approval and also allow for variations in dialect within an enrolled population.

- *Issue quality guidelines for interpreter services.* Both health plans and providers urge states to establish clear but flexible definitions of what is adequate with respect to interpreter services. Opinion is mixed on the value of mandatory interpreter certification: plans and providers are principally concerned about cost, but they are also wary of overregulation by the states. Some are familiar with the mandatory certification process in Washington State, where, for certain Asian languages, few native speakers have successfully passed the certification exams. Organizations that support the concept—primarily providers—feel that more specific standards are needed. At the same time, they also argued for a kind of risk adjustment in setting premiums and capitation rates for multilingual services. At a minimum, issuing standards for voluntary interpreter certification would assist organizations that desire guidance as to what constitutes an appropriate level of service.

- *Develop practical tools for the assessment of provider proficiency in other languages.* Most plans are required to assess and report on their own member services staff and on network provider proficiency in non-English languages. Plans report that the lack of a standard set of instruments presents a difficult problem, especially if each plan or provider organization uses a different instrument and clinical providers are subject to multiple tests.

Data systems capable of tracking and providing information about care delivery, differentiated by population characteristics, will be needed to identify the specific health needs of multicultural populations and to assess the competence of the plans and providers serving them.

For this study, we proposed a measure of cultural competence in managed care that focuses on the outcome of a health care encounter, episode of care, or overall membership in a health plan with regard to patient satisfaction, health status, and cost-effectiveness. We found, however, that California's and other states' Medicaid programs did not yet have the information by which the quality of care could be assessed and areas for improvement

identified. Quality and oversight are especially important when low-income, culturally diverse populations are moving to a health care system based on limited choice.[3]

- *Assess the validity of demographic databases used by state Medicaid managed care programs and departments.* Most states have implemented some type of database that collects information on Medicaid beneficiaries regarding race, ethnicity, and language preference; in California, the MEDS database serves this function. Studies on the validity of these databases are urgently needed. If the data are determined to be of acceptable quality, then health plans, providers, and researchers could proceed with evaluations of services provided and consumer satisfaction by race/ethnicity and language group. Currently, such evaluations are very sporadic and are difficult to implement effectively across plans. If the data are unusable and cannot be improved, then other approaches, including targeted surveys and research, should be undertaken.

- *Assess the validity and utility of the information collected in the initial patient assessments.* Most states that have already implemented Medicaid managed care have some provision requiring or encouraging beneficiaries to see a primary care provider within a certain number of days following enrollment. In California, Medi-Cal managed care beneficiaries are supposed to schedule their visit within the first 120 days of enrollment. Presumably, information about race/ethnicity and linguistic needs collected in this setting is more reliable than that volunteered by beneficiaries during the eligibility determination process. Little has been done, however, to test such matters as the cost and difficulty of gathering these data in states that collect demographic information during the first PCP visit.

- *Link race/ethnicity and linguistic group to utilization patterns in Medicaid managed care.* This will be a substantial and initially complex task, as most states are not yet able to collect encounter-level data from managed care providers in a reliable and systematic way. One California contractor, MedStat, has been working with the state to design a method for collecting these data, but state officials are uncertain about plans' ability to use the system. A study should be considered to examine how other states are addressing these data needs and what alternative approaches can effectively link race, ethnicity, and linguistic need to care utilization patterns.

- *Evaluate the additional cost of providing care to multicultural and non-English-speaking populations.* Preliminary studies have identified variations (adjusted for age and sex) in costs between Medicaid and commercially insured enrollees in managed care plans.[4] The impact of cultural competency provisions has not been calculated. As

[3] R. Lavizzo-Mourey and E.R. Mackenzie, "Cultural Competence: Essential Measurements of Quality for Managed Care Organizations," *Annals of Internal Medicine* 124 (10):919–921.

[4] W.P. Welch and M. Wade, "The Relative Cost of Medicaid Enrollees and the Commercially Insured in HMOs," *Health Affairs* 14 (2):212–223.

providers and plans become more experienced in analyzing the cost of services under managed care, they will be able to parse out the incremental cost of translations, interpreter services, extended office visits, training for health professionals, and other culturally competent services. Oregon and a few other states are considering using risk adjustment in reimbursing plans for these costs. In California, experiments with risk adjustment for commercially insured populations—adjusting for the burden of disease and injury, but not for linguistic needs—may begin in 1999. Inclusion of cultural and linguistic service needs as a risk adjuster in Medicaid rates has not been proposed by most states.

- *Achieve as much consistency as possible in services provided through state-financed health care programs.* Many states have numerous publicly financed programs that serve similar populations yet use different requirements and methods of implementation. California, for example, will not apply all Medi-Cal managed care cultural competence requirements to its Healthy Families child health insurance program. A number of other states have mental health and other Medicaid managed care carve-outs that vary from the state Medicaid managed care program. Attempts should be made wherever possible to rationalize requirements across publicly financed programs.

A substantial caveat should be appended to this discussion. Owing to the brief periods during which many beneficiaries are eligible for Medicaid, attempts to correlate utilization and outcomes with the quality of cultural and linguistic services provided by health plans and providers may be misleading. In fact, it may be more correct to undertake studies of this type to characterize *existing variations* in the patterns of morbidity and health services utilization in multicultural populations. Over time, an adequate method for collecting information on access, quality, and satisfaction may allow states to discriminate among plans and providers.

Experimentation and innovation in culturally competent care by health plans and providers has yet to be evaluated and captured adequately. A common system for evaluating quality across plans and providers would reduce the tendency to reinvent the wheel. Providers and plan administrative staff frequently reported that they were interested in implementing innovative programs that they knew of in their state or elsewhere in the country. However, they did not know how the programs had been implemented or whether they had been successful. Efforts to gather information on various programs, evaluate them, and provide technical assistance to programs wishing to adopt specific approaches would help expand the provision of multicultural health services in California and other states. Providers and plans mentioned the need for “best practices” or practice guidelines for member services, health education, and patient care.

National accreditation programs for managed care providers should include a cultural competence component by which differences in process and outcomes measures by racial/ethnic or linguistic group can be examined.
Harvard Medical School, the RAND Corporation, and the Research Triangle Institute developed the Consumer Assessment of Health Plans Survey (CAHPS) for the Agency for Health Care Policy and Research (AHCPR). The National Committee for Quality Assurance is working with AHCPR to achieve integration of parts of CAHPS into the Health Plan Employer Data and Information Set (HEDIS). This is an important step, because it will support the routine collection of information on race/ethnicity and language and introduce a practical means of assessing relative cultural competence among plans and providers. Efforts to expand this initiative and to support plans and providers in responding to it should be encouraged.

Medicaid contract requirements have had a substantial impact on health plan services and operations, yet efforts to provide culturally competent services linked to patients' health status and health outcomes are still in their infancy. One of the primary barriers to implementation of culturally competent services is lack of data. Efforts need to be initiated to develop and validate meaningful tools to assess the specific health needs of multicultural populations as well as providers' and plans' ability to meet these needs. National accreditation programs for managed care providers should be encouraged to support measures of cultural competence that differentiate outcome measures by race, ethnicity, and language. As more states turn to risk adjustment for setting insurance premiums, the evaluation of culturally competent services will become increasingly important.

MEDICAID MANAGED CARE AND CULTURAL DIVERSITY IN CALIFORNIA

OVERVIEW

Approximately 48 percent of all Medicaid beneficiaries in the United States are now enrolled in a managed care program.[5] California operates the nation's largest and most diverse Medicaid managed care program: 36 percent of residents who were eligible for Medi-Cal (the state's Medicaid program) as of October 1997 were enrolled in a managed care plan.[6] By the close of 1998, more than 3 million Medi-Cal eligibles will be enrolled in a commercially or county-operated plan. This mass transfer of culturally and ethnically diverse Medicaid populations into managed care has led federal and state agencies across the country to address concerns about the cultural competency of plans in delivering health care services to their patients.[7] Public and private officials alike are asking, "Can managed care, designed to meet the needs of commercially insured and Medicare populations, adequately serve the more specialized needs of its diverse new members?"

Moving Toward Culturally Competent Care

One-quarter of Americans will be members of racial or ethnic minority groups by the year 2000, and more than two-thirds of California's population will be members of minority groups by 2025.[8] Not only do the incidence of disease and the efficacy of medical treatments vary across minority populations, but each group—like the white non-Hispanic population—has its own distinct patterns of health beliefs, values, and behaviors, all of which can significantly affect compliance with prescribed treatments.[9] As medicine has become increasingly concerned with the efficient use of resources to produce improved health outcomes, the importance of these cultural variations has grown. Physicians, hospitals, and other providers have consequently begun to evaluate their own cultural competence.[10]

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[5] Health Care Financing Administration, Medicaid Managed Care Enrollment Report, last updated March 3, 1998.

[6] California Department of Health Services, Medi-Cal Eligibility Branch, Eligibility File Report for October 1997.

[7] R. Lavizzo-Mourey, "Cultural Competence: Essential Measurements of Quality for Managed Care Organizations," *Annals of Internal Medicine* 124 (10):919–921.

[8] "Projected Population Composition, 2025," American City Business Journals web site (www.amcity.com/journals/demographics/report37/37-3.html), based on U.S. Bureau of Economic Analysis and ACBJ research.

[9] Recent literature documenting these patterns includes E.A. Friedman, "Diabetic Nephropathy in Blacks," *Transplant Proceedings* 25 (1993):2431–2432; E.B. Fisher et al., "Targeting High-Risk Groups: Neighborhood Organization for Pediatric Asthma Management in the Neighborhood Asthma Coalition," *Chest* 106 (suppl. 1 1994):248S–259S; D.J. Hufford, "Gender, Culture and Experience: A Case of Fatal, Painful Miscommunication," presented at the conference "Human Diversity in Health Care," Philadelphia, March 18, 1996; C.C. Lang et al., "Attenuation of Isoproterenol-Mediated Vasolidation in Blacks," *New England Journal of Medicine* 333 (1995):155–160; E. Saunders, "Hypertension in African-Americans," *Circulation* 83 (1991):1465–1467; and R. Lavizzo-Mourey, "Cultural Competence: Essential Measurements of Quality for Managed Care Organizations," *Annals of Internal Medicine* 124 (10):919–921.

[10] M. Blanton and B. Lyons, "Managed Care and the Low-Income Population: Insight from Recent State Experiences," Kaiser Commission on the Future of Medicaid, Washington, D.C., 1997.

Some health plans have launched programs to improve services for minority enrollees and help the plans' provider networks learn how to deliver culturally responsive services. Although a 1995 survey identified only four states (California, Maryland, New York, and Vermont) that required hospitals to provide language interpreters,[11] a growing number of states have begun to assert their interest in protecting vulnerable and underserved populations—particularly minority communities—principally by requiring that health plans meet the linguistic needs of non-English-speaking enrollees.[12] Nearly three-quarters of all states require under their Medicaid managed care contracting provisions that plans and providers make written materials available in other languages; close to half require language interpreter services for clinical and administrative encounters.[13] In addition, nearly two-thirds of all Medicaid managed care contracts have some cultural competency requirements that are non-language-specific.[14]

Only limited research has been done to assess the impact of cultural competency provisions on Medicaid managed care providers, regulators, and enrollees. In order to study the system-wide impact of these requirements in California—where one-third of Medi-Cal beneficiaries mandatorily enrolled in county plans indicate a language other than English as their primary language—The Commonwealth Fund commissioned The Lewin Group to examine the mechanisms through which plans and providers have implemented state policy.[15]

Defining Cultural Competence

The term "cultural competence" has been used to describe efforts on the part of health plans and providers to deliver specialized services to their non-English-speaking, ethnically diverse enrollees.[16] According to a 1995 study by the Henry J. Kaiser Family Foundation, the ability of providers to communicate fully and effectively with all their patients is the first step in progressing from "cultural sensitivity" to "cultural proficiency."[17] While cultural sensitivity

[11] C. Ginsburg, D. Andrulis, and V. Martin, *Interpretation and Translation Services in Health Care: Survey of U.S. Hospitals Public and Private Teaching Hospitals,* National Public Health and Hospital Institute, Washington, D.C., March 1995. (Cultural competency training to English-speaking ethnic and racial minorities was not included in the survey.)

[12] S. Rosenbaum and P. Shin, *Medicaid Managed Care: Opportunities and Challenges for Minority Americans,* George Washington University Medical Center, October 1997.

[13] Center for Health Care Policy Research, *Negotiating the New Health-Care System: A Nationwide Study of Medicaid Managed Care Contracts,* Washington, D.C., 1997.

[14] J. Perkins, H. Simon, F. Cheng, K. Olson, and Y. Vera, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities,* The Henry J. Kaiser Family Foundation, Menlo Park, CA, January 1998.

[15] California Department of Health Services, Medi-Cal Managed Care Division, *Eligibility File Report and Month of Eligibility,* September 1997.

[16] Very few data exist on the provision of culturally competent services to English-speaking minorities; most information is qualitative in nature and programmatically descriptive.

[17] J. Perkins, H. Simon, F. Cheng, K. Olson, and Y. Vera, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*, The Henry J. Kaiser Family Foundation, January 1998; P.H. Chang, J.P. Fortier, "Language Barriers to Health Care: An Overview," *Journal of Health Care for the Poor and Underserved* 9 (1998 Supplemental):S5–S20; T.L. Cross, B.J. Bazron, K.W. Dennis, M.R. Issacs, *Toward a Culturally Competent System of Care,* Vol. 1, Georgetown University National Technical Assistance Center for Children's Mental Health, Washington, D.C., 1989.

indicates a health provider's awareness and understanding of the cultural and ethnic dimensions of patient health, cultural competency represents the capacity of the provider to produce desired health outcomes by working with patients to customize treatment and services.[18]

Developing a culturally competent system of care is consistent with the recent shift toward accountability for results or outcomes, rather than measures of process, in health care purchasing and health services delivery systems. From a practical perspective, cultural competence may be measured directly as the health outcome of an episode of care, the patient's satisfaction with the encounter, and the cost-effectiveness of the intervention. This functional definition of cultural competence not only emphasizes the importance of assessing patient satisfaction in diverse communities, but may also help promote cultural competence among purchasers, insurers, and providers by using a set of outcomes standards and measures that are already widely in use.[19] For the purpose of this study, cultural competence is defined as the ability to provide services that yield the desired clinical outcome combined with a high degree of patient satisfaction.

METHODOLOGY

To better understand how providers and health plans in California are incorporating cultural competence in the delivery of services to Medi-Cal managed care members, we conducted a series of telephone interviews with county-operated and private managed care plan managers, state and county officials, physicians, community-based clinical care providers, and other key stakeholders in California (see Appendix A for a list of organizations contacted). In selecting the key informants, we considered:

- their role in designing and implementing the 1993 Plan for Expansion of Medi-Cal Managed Care;
- their current role in developing Medicaid policy at the state or county levels and/or in implementing the Medicaid managed care program;
- whether they currently serve in a decision-making capacity with a managed care plan;
- whether they are leaders in the research, advocacy, or delivery of culturally competent health care services;

[18] M. Isaacs-Shockley, *State of the States: Responses to Cultural Competence and Diversity in Child Mental Health,* Georgetown University Child Development Center, Washington, D.C., 1997.

[19] A. Stewart et al., *Interpersonal Processes: Evaluating Quality of Care in Diverse Populations,* Institute for Health Policy Studies, University of California at San Francisco, January 1997.

- whether they were identified by at least two different sources as providing valuable information and perspective;

- whether they were identified in our literature review; and

- whether the group as a whole represented a variety of perspectives.

We also analyzed aggregate Medicaid eligibility and enrollment data at the state and county levels and reviewed current research studies focused on cultural diversity and clinical care. In addition, interviews with key stakeholders in Washington, Oregon, and Arizona were conducted to learn about other states' experiences.

PROGRAM EXPANSION AND IMPLEMENTATION

Background

In 1993, California announced its intention to transfer more than 3 million mostly nonrural Medi-Cal beneficiaries into managed care health plans over several years.[20] Managed care was not new to California's Medi-Cal population. The first attempt to move the state's Medicaid population into managed care, in the early 1970s, had been halted as a result of fraud and other problems. By the 1980s, however, mandatory enrollment was being implemented in several county-operated health plans (through County Organized Health Systems, or COHS), and a large number of primary care case management (PCCM) plans were offering voluntary enrollment. More than 600,000 Medi-Cal beneficiaries were already enrolled in managed care plans by 1993.[21]

California's strategy was motivated by a desire to expand access to health care for the state's financially challenged populations and to improve the cost-effectiveness of the state's Medi-Cal service system through increased competition. In Sacramento and San Diego counties, which do not have public hospital systems, the state instituted mandatory enrollment of Medicaid beneficiaries into managed care by contracting directly with private health plans through the competitive bid process known as geographic managed care. Twelve additional counties—the most populous in the state—were encouraged to develop local health plans that would be operated by either the county or a quasi-public organization of traditional providers. Medi-Cal beneficiaries in these counties were required to choose between a "mainstream" (commercial) health plan or the locally operated plan, otherwise known as the local initiative.

[20] California State Department of Health Services, *Plan for Expansion of Medi-Cal Managed Care,* 1993.

[21] Letter from the Director, California Department of Health Services, accompanying *Expanding Medi-Cal Managed Care,* 1993.

Medi-Cal Requirements for Cultural Competence

Previous attempts to transfer the Medi-Cal population into managed care had provided state officials with important lessons for implementing mandatory enrollment.[22] Rather than rely on the more traditional tool of regulation, California decided to employ detailed requirements in health plan contracting to ensure the provision of effective services for its diverse Medicaid population. The state also hoped to stimulate competition among mainstream plans by adopting the Cultural Index of Accessibility to Care—a system for rating culturally competent service requirements—for use in the competitive bidding process.[23] The 1993 plan also incorporated proposals from the Latino Coalition for a Healthy California, the California Urban Indian Health Council, the California Pan-Ethnic Health Network, and Asian Health Services. Both the Cultural Index and the consumer proposals led to the creation of eight contracting provisions focused on increasing access to interpreter and translation services to non-English-speaking Medi-Cal managed care enrollees.

The 1993 plan defined culturally appropriate care and emphasized its importance in services to Medi-Cal beneficiaries:

> "'Culturally appropriate' means the capacity of individuals or organizations to effectively identify the health practices and behaviors of target populations; to design programs, interventions, and services which effectively address cultural and language barriers to the delivery of appropriate and necessary health care services; and to evaluate and contribute to the ongoing improvement of these efforts. Such consideration facilitates access to care, improves patient satisfaction, promotes compliance with treatment regimens, and facilitates more effective health promotion efforts. Ultimately, culturally appropriate services are an important factor in improved health outcomes…. Services provided to Medi-Cal beneficiaries by managed care plans must be directed toward meeting tangible objectives for cultural appropriateness."[24]

To draft the contract requirements, the California Department of Health Services convened a task force comprising representatives of traditional providers, consumer groups, and mainstream health plans. Because of California's burgeoning non-English-speaking immigrant population, the primary focus of the contracting provisions was narrowed from the promotion of culturally competent services for all ethnic, racial, and linguistic minorities to the provision of services that ensure linguistic access. Originally, the state proposed to

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[22] *Medicaid Managed Care Delays and Difficulties in Implementing California's New Mandatory Program*, U.S. General Accounting Office, GA/HEHS-98-2.

[23] M. D. Tirado, "Tools for Monitoring Cultural Competence in Health Care," final report to the Office of Planning and Evaluation Health Resources and Services Administration by the Latino Coalition for a Healthy California, January 1996.

[24] *Expanding Medi-Cal Managed Care*, California Department of Health Services, 1993.

require linguistic services in geographic areas where 10 percent of the Medi-Cal population did not speak English. The state found, however, that many populations in need of linguistic services would be excluded under this formula because they were either too large and dispersed or too small and concentrated.

As a remedy, the task force introduced *threshold and concentration standards* for the provision of services to non-English-speaking populations. Under Medi-Cal's cultural and linguistic competency contracting requirements, linguistic services must be provided in areas that meet either the threshold standard of 3,000 beneficiaries per language group or the concentration standard, defined as 1,000 beneficiaries in a single ZIP code or 1,500 in two contiguous ZIP codes. The effect becomes clear when considering Fresno County's Hmong Medi-Cal managed care beneficiaries. Although their total numbers are too small to qualify under the 10 percent method, Hmong residents nevertheless have access to linguistic services, since they are concentrated in only a few service areas.

Table 1 depicts the language groups by county that met threshold and concentration standards in 1997. While numerous counties now track threshold concentrations, only the 12 counties under California's two-plan model approach are required to report on threshold concentration standards. Under this approach, the California Department of Health Services (CDHS) contracts with one local initiative managed care plan and one commercial plan in each county to serve Medi-Cal beneficiaries. The two-plan model was designed to shift large segments of the Medi-Cal population into managed care while preserving the role of traditional providers and allowing for choice and competition.

Table 1. Language Groups Meeting Threshold and Concentration Standards for Linguistic Services in Two-Plan Counties

	Language							
County	**Spanish**	**Vietnamese**	**Cantonese**	**Cambodian**	**Lao**	**Hmong**	**Armenian**	**Russian**
Alameda	x	x	x					
Contra Costa	x							
Fresno	x					x		
Kern	x							
Los Angeles	x	x	x	x			x	x
Riverside	x							
San Bernardino	x							
San Francisco	x	x	x					
San Joaquin	x	x		x				
Santa Clara	x	x						
Stanislaus	x			x				
Tulare	x				x			

Source: California Department of Health Services, Medi-Cal Managed Care Division, 1997.

This concentration requirement has encouraged local initiatives to provide linguistic services even for some populations that fall short of the standards. Alameda County, for example, initially had four threshold languages based on 1994 data: English, Spanish, Vietnamese, and Farsi. By 1997, data on Medi-Cal eligible beneficiaries had shown that Farsi had fallen below the threshold. The Cambodian population was now larger than the Farsi population, although it, too, failed to meet threshold criteria (each constituted approximately 3 percent of the enrolled population). Representatives from Alameda County's local initiative reported, however, that the full range of linguistic services was still being provided in Farsi and was beginning to be offered in Cambodian. Evidently, these services were found to be effective in meeting member needs and the plan's need to communicate with its enrollees.[25]

In addition to the threshold and concentration provisions, the contract requirements include eight provisions to ensure cultural competency, five of which specifically address interpretation and translation services. The provisions require all participating health plans to:

1. provide all members having limited English proficiency with 24-hour access to linguistic interpreter services over the telephone or to interpreters available on site

2. provide non-English-speaking members in each eligible service area with additional linguistic services covering:

    - information on plan coverage
    - health education programs
    - health care provider orientation and training
    - appointment scheduling
    - medical advice phone lines
    - membership assistance
    - satisfaction surveys

3. assess and report the linguistic capability of interpreters employed or contracted by the plan

4. establish a community advisory committee to assist in developing and monitoring culturally competent services

5. conduct an internal needs assessment and formulate a plan to meet the cultural and linguistic services needs of enrollees within 12 and 18 months, respectively, of contracting with the state

[25] Personal communication with Alliance for Health of Alameda County, April 1998.

6. monitor the provision of providers' linguistic services

7. develop and implement standards and performance requirements for the provision of linguistic services and monitor the performance of individuals offering such services

8. implement an interpreter coordination system and set standards for coordinating appointment scheduling with interpreter services[26]

Recognizing that some plans would not be able to comply with these requirements immediately, the state allowed plans to submit a work plan to attain compliance.[27] The Policy and Quality Improvement Branch of the Medi-Cal Managed Care Division of the CDHS has the responsibility for developing policies and technical assistance—with the support of the CDHS Office of Multicultural Health—to help achieve cultural and linguistic competence in health plan and provider operations.

Plan Selection and Oversight

All mainstream health plans applying to operate in the 12 counties targeted for Medi-Cal managed care were judged competitively in 10 categories, including one for cultural and language requirements. According to CDHS staff, the inability to meet the cultural and language requirements contributed to the rejection of several plans.

Once plan selection was complete, the CDHS implemented oversight measures to ensure compliance with the requirements. Plan and provider performance was monitored for availability of interpreter and translation services, ability to meet patients' needs, and nature of patients' grievances and complaints. The CDHS also implemented approval protocols for updated operational plans and the translation of all materials distributed to members. Detailed policy memos became an effective tool to provide plans and providers with specific guidance on meeting the requirements. Finally, the CDHS convened the advisory Cultural and Linguistic Standards Task Force to draft recommendations and provide advice on the implementation of the program.

Cultural Competence in Health Plan and Provider Operations

In order to better understand the mechanism used by plans and providers to meet the state's requirements for cultural competence, we examined six core operational functions: enrollment, member services, provider networks, access to care, quality and utilization patterns, and provider services. Telephone interviews were conducted with managed care plan managers and state and county officials, enrollment data was analyzed, and current

[26] Medi-Cal Contract Language for Participating Plans, Office of Medical Managed Care Policy and Quality Improvement.

[27] California Department of Health Services, accompanying *Expanding Medi-Cal Managed Care*, 1993.

research studies were reviewed. (For a detailed case study of Alameda County's Alliance for Health, the first Medi-Cal managed care expansion plan, see Appendix B.)

Enrollment. Once individuals are determined to be eligible for Medi-Cal, they begin the enrollment process, known as Health Care Options.[28] Beneficiaries receive enrollment packets containing general information on managed care and the Medi-Cal program, along with provider directories and enrollment forms. They are also encouraged to call toll-free numbers for additional information, available in 10 languages. In addition, beneficiaries are offered the opportunity to attend presentations explaining managed care and the various options available.

Beneficiaries are next asked to select a plan and a network primary care physician (PCP). If they fail to respond or do not select a plan and a PCP, they are assigned by default to one of the available plans in their service area. In many cases, default beneficiaries are assigned to the local initiatives, since the state is committed to maintaining enrollment in the them at levels necessary to retain federal disproportionate share payments for California's public hospitals. Once a participating health plan is assigned, a second default assignment matches the beneficiary with a provider based on language and geography.

Many counties have experienced serious obstacles to enrolling beneficiaries. Default assignment rates have been persistently high—averaging 25 percent—in most counties.[29] (See Appendix C for county-by-county enrollment). Enrollment difficulties in Los Angeles County were so severe that the Health Care Financing Administration (HCFA) was forced to halt enrollment in Medi-Cal managed care. Such problems suggest that outreach and education efforts have not yet achieved their objectives.

One factor that may be contributing to the high default rate is the lack of contractual or financial incentives to improve performance: Health Care Options has redesigned its enrollment process but is still reimbursed by the state for each enrollment, disenrollment, and re-enrollment.[30] According to some interviewees, beneficiaries often fail to make voluntary selections because of lack of understanding of the enrollment process, absence of a preferred provider from the available list, or lack of interest.

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[28] An independent broker handles beneficiaries' enrollment in order to deter direct marketing abuses.

[29] *Monthly Enrollment Summaries*, Health Care Options Division, California Department of Health Services, 1998.

[30] The redesigned enrollment process used in all of the expansion counties now includes: (1) a general letter introducing Medi-Cal managed care, the plans available for selection, and the process of enrollment 30 days before the selection deadline; (2) the enrollment packet; (3) an "intent to assign" letter warning of the approaching deadline if a beneficiary does not make a selection; (4) an "intent to default" letter if the beneficiary still has not responded; and (5) an assignment letter enrolling the beneficiary in the default plan for that service area.

The enrollment process is the point at which information about race, ethnicity, and language of preference is collected and stored in the Medi-Cal Eligibility Data System (MEDS), the demographic database for the Medi-Cal program. The accuracy of this information, however, has not been determined. According to Medi-Cal staff and health care providers, some non-English-speaking eligibles do not list their primary language out of fear that this disclosure will make them ineligible; others list a non-English-language preference and then complete eligibility forms in English. More detailed and presumably more accurate information on race, ethnicity, and language preference is gathered by the primary care provider, who must see each beneficiary within 120 days of enrollment.

Member Services. Health plans' member services departments assist plan members in understanding their benefits packages, answer inquiries, and respond to complaints. Each of the plans participating in Medi-Cal managed care has dedicated department staff and established programs to comply with California's language and cultural requirements, including the translation of member services information, educational materials, and satisfaction surveys into each of the threshold languages.

The process of obtaining usable translations, testing them, and having them approved by the state was uniformly reported by plans to be difficult. However, providers and community-based organizations—which are contracted by several counties to pre-test translations—regarded the testing processes and the availability of the translations themselves to be important for member services and patient care.

Plan representatives stated that CDHS contract requirements for cultural and language services were an important factor in their planning for member services. In particular, they cited information provided by the state regarding language needs within plan service areas as especially useful. This information led some plans to provide specialized member services for populations not meeting state criteria for required services. Blue Cross of California, for example, established community resource centers for member services, appointment scheduling, and intake needs assessments, and for reminding enrollees of their required initial PCP visit and the need for preventive services and prenatal care. The centers' staff, who are representative of the ethnic and linguistic demographics of the communities they serve, receive training in outreach and education and are encouraged to act as patient advocates.

Although all plans provide cultural competency training for member services personnel, several program directors stated an interest in finding more detailed educational programs for additional training of both their staff and contracted health care providers. In most cases, health plans have gone well beyond minimal compliance in identifying opportunities in plan or provider operations.

Provider Networks. Medi-Cal policy stipulates that the local initiatives must include all traditional providers in their managed care networks, including community health centers and public hospitals that have historically cared for substantial numbers of Medi-Cal patients. In addition, mainstream health plans were selected in a competitive bidding process that scored the adequacy of provider networks, including traditional provider representation and appropriate language services. These requirements are widely acknowledged to have given traditional providers a significant advantage in obtaining managed care contracts, even within mainstream health plans.

Blue Cross, for example, has used an "any willing provider" approach in which nearly all providers with Medi-Cal patient bases are accepted. As a result, it has expanded its physician network significantly to include many minority physicians who had not previously had access to managed care contracts. The Medi-Cal requirements have also encouraged public hospitals to continue to make multicultural services available to Medi-Cal beneficiaries.

Access and Satisfaction. A recent study of patient satisfaction with care involving members of a group-model HMO found higher rates of satisfaction among those patients who chose their own PCP than those who were assigned a physician. The correlation between satisfaction and choice may be related to the desire for patients to pick physicians of a similar ethnic background, who may share their values and understand their needs.[31] For some populations, such as the Hmong, plans noted that there were simply not enough physicians who could speak the language. Blue Cross explained that it relies on its culturally diverse staff and language services to meet members' needs.

National studies comparing patients' access to care in Medicaid managed care plans with that in fee-for-service systems—including one conducted by the Center for Health Policy Research for the Kaiser Commission on the Future of Medicaid—provide mixed results.[32] Under California's previous fee-for-service program, Medi-Cal beneficiaries had experienced difficulty gaining access to primary care and specialty care. The transition to managed care was designed to increase access to primary care by providing them with a medical home, through a primary care provider, and making health plans responsible for providing access to specialists. Cultural competence requirements have allowed for a larger percentage of non-English-speaking Medi-Cal beneficiaries to have access to primary care physicians and specialists who speak their language, or at least to interpreter services for encounters with those doctors who do not.

[31] J. Schmittdiel, J. Selby, K. Grumbach, and C. Queensberry, "Choice of a Personal Physician and Patient Satisfaction in a Health Maintenance Organization," *Journal of the American Medical Association* 278(19):1596–99.

[32] D. Rowland, S. Rosenbaum, L. Simon, and E. Chait, *Medicaid and Managed Care: Lessons from the Literature,* The Henry J. Kaiser Family Foundation, April 1995.

Medi-Cal patients, though, have not yet achieved a level of access on par with that enjoyed by commercially insured populations. A 1997 survey of managed care plan members sponsored by several California health foundations found that 42 percent of Medi-Cal beneficiaries experienced difficulties with their plans in seeking health care services, including delay or denial of services during the previous 12 months. By contrast, only 27 percent of all managed care households (Medi-Cal inclusive) experienced these problems.[33] To help improve access, each of the several Medi-Cal local initiatives that reported plan surpluses at the end of the first year of operation has allocated a portion of the money to community education, risk prevention, and disease management initiatives targeting non-English-speaking populations.[34]

Quality and Utilization Patterns. Mainstream managed care plans and providers monitor health care utilization patterns among members to detect problems of inappropriate over- and under-use of services, such as pediatric asthma hospitalizations and immunizations. One of the state's objectives in shifting Medi-Cal beneficiaries into managed care was to extend this monitoring and management of care to the Medi-Cal population. Yet because of the lack of reliable data—even within the MEDS database—most plans and providers have only begun to analyze utilization patterns by racial, ethnic, or linguistic group.

In contrast, both mainstream plans and local initiatives have analyzed member satisfaction data broken down by such groupings. Solano County, for example, has gathered ethnic and race-specific data on enrollees to help redesign future member services. In Alameda County, the Alameda Alliance for Health hired and trained plan members enrolled in GAIN, an employment program, to conduct telephone and in-person interviews for its member satisfaction survey.

Provider Services. Overall, health care providers reported far fewer changes than health plans in staff or services as a result of the Medi-Cal cultural and linguistic requirements. Solo practitioners did report using the 24-hour telephone interpreter service, but they usually could not afford to hire additional staff. On the other hand, community clinics, including federally funded neighborhood health centers, have been able to maintain or expand their client base, and most have added staff accordingly. These clinics, though, already had a range of linguistic and health care programs in place for their non-English-speaking populations. Providers interviewed for this study uniformly felt that the principal effect of Medi-Cal contract requirements has been to expand health plan networks to include them.

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[33] *Preliminary Findings: Survey of Consumer Experiences in Managed Care*, prepared by The Lewin Group for The Henry J. Kaiser Family Foundation, Sierra Health Foundation, and California Wellness Foundation, November 1997.

[34] Unlike mainstream plans, local initiatives are public or quasi-public organizations and thus make their financial reports available.

One important change has been the development of independent community health worker programs that contract directly with plans to help providers with the complexities of chronic disease management and prenatal care across multiple diverse communities. Santa Ana's Latino Health Access Project, for instance, provides classes in Spanish to educate diabetic Latino patients about their condition. At least 90 percent of program participants have managed to reduce their hemoglobin A1C levels by as much as 50 percent.[35] Blue Cross and other plans contract with community-based organizations to assist with individual patient management as well as community health education. Most health plans reported that they will begin analyzing some patterns of utilization by ethnic and linguistic groups this year. As problems in utilization and chronic disease management are identified, plans may increase their use of community health workers to reach patients directly.

The County of Los Angeles has an anomalous arrangement whereby the local initiative (LA Care) subcontracts with seven mainstream plans. LA Care has made substantial investments in the development of an umbrella information system and plans to analyze utilization data by ethnic group as well as geographic subregion. It also plans to certify translators, offer training courses for providers, and monitor grievances by plan and linguistic group. LA Care reports that Kaiser Permanente in Los Angeles has developed a broad program for cultural competence and that its leadership in clinical care is important for the diverse populations of the county. UHP Healthcare, a plan that developed from a large neighborhood health center in the 1980s, also has a long history of training providers and developing materials and educational programs for patients in several languages.

Issues Raised by Health Plans and Providers

From our interviews with mainstream and local initiative health plans and providers, we identified four key factors that are limiting their ability to provide culturally competent services to Medi-Cal members: the lack of adequate financial incentives available to attract physicians; the challenges of tracking members' race, ethnicity, and language in the provider's office; the lack of analytical support to validate MEDS data and use these data for comparative analyses across plans, member subpopulations, and geographic regions; and the need to move beyond linguistic competence.

Financial Incentives. As they do elsewhere throughout the health care system, incentives within Medi-Cal operate at many levels. Physicians have become more interested in participating in Medi-Cal because managed care has reduced the overall demand for physician services in California. Medi-Cal's shift to capitated payments also provides doctors with more predictable revenue and the opportunity to manage the provision of services.

[35] E. J. Koch, P. Keegan, S. Johnson, *Community Health Workers: Meeting the Needs of People in a Changing Health Care System,* The Robert Wood Johnson Foundation, Princeton, NJ, 1997; and personal communication with Latino Health Access, Santa Ana, CA.

Interest shown by medical groups and independent practice associations (IPAs) in participating in Medi-Cal managed care provides further stimulus for physicians to provide linguistically appropriate services. Medical groups and IPAs that enroll substantial numbers of Medi-Cal beneficiaries frequently assist providers and their office staff in the appropriate use of language services. In Los Angeles County, for example, plan managers reported frequent examples of minority physicians hiring nurses from different minority groups in order to expand the cultural reach of their practice.

Medi-Cal health plans and providers, however, do not receive increased premiums or capitation rates for services provided to non-English-speaking members. Plan representatives reported concern about the expense of these services and about the operational difficulties—principally the cumbersome nature of the state review process for translations—encountered in providing them. Providers also noted the additional cost of maintaining bilingual services for threshold populations and suggested the need for "risk adjustment" in the capitation rate for non-English-speaking patients.

Operational Concerns. The most difficult and complex issue raised by both plans and providers—as well as Medi-Cal staff—was that of defining and tracking the adequacy of linguistic services in the provider's office. Although the state and most health plans offer education to providers on the appropriate use of these services, problems persist nevertheless. For example, patients frequently use family members as interpreters, even though the state discourages this practice. One provider reported that a colleague, an African American physician, relied on his receptionist to interpret for his large Vietnamese patient population. However, since she was not available to translate after office hours, he worried whether his patients were postponing calls and visits to see him. High turnover in doctors' office staff poses another problem for plans in tracking languages spoken.

To help remedy this situation, the state's Cultural and Linguistic Standards Task Force recently drafted guidelines and a training curriculum for interpreters. The Medi-Cal managed care program will incorporate the guidelines into a policy letter to be issued in the near future, and plans will be able to use them to assess their interpreters' capabilities. The California Health Interpreters Association is also exploring the possibility of creating a formal certification process for medical interpreters—an effort supported by the CDHS.

As noted earlier, all of the health plans felt that the process of state approval for translations of written materials distributed to members was too cumbersome and unnecessarily delayed member communications. Several plans suggested that the state approve in advance organizations or individuals to provide translation services for written materials and then allow plans to have materials translated and distributed directly.

Plans have also experienced varied success in establishing community advisory committees as required. Some plans reported difficulty in defining the objectives of their committees and maintaining participation where the service area is large and consumer interest is low. Other plans, however, have very active committees that review all cultural and linguistic services, written materials, satisfaction surveys, and group needs assessments and make recommendations to the plan on health and linguistic services.

With regard to state oversight, all plan representatives interviewed found the CDHS too prescriptive in its approach. Plans should be allowed to innovate, they argued, in putting together systems that will be the most appropriate for their own structure and services, and to demonstrate the effectiveness of their programs. Medi-Cal, however, points out that since neither the plans nor the state presently have the capacity to analyze utilization or outcomes by race, ethnicity, or linguistic group, assessing and comparing the effectiveness of alternative approaches would be difficult.

Analytic Support. The MEDS database draws demographic information from Medi-Cal eligibility determinations for which the validity of the race/ethnicity and linguistic group data gathered has not been assessed. Moreover, this information has not been used in analyses of utilization data to produce profiles of events such as primary care preventable hospitalizations. California plans to implement the recently developed Medicaid Consumer Assessment of Health Plans Survey (CAHPS), which includes information on race/ethnicity and language, to provide analyses of certain indicators of service utilization and health status as well as satisfaction.

Moving Beyond Linguistic Competence. Most interviewees acknowledged that Medi-Cal plans and providers are currently preoccupied with the complexities of providing appropriate linguistic services and have only begun to grapple with questions of culture and medicine. Though plans and providers have organized educational programs for their staff, they have generally not assessed the cultural (other than linguistic) competence of their personnel or delivery of services. Several notable exceptions do exist, including Asian Health Services, a large neighborhood health center in Oakland. The center has established an interpreter training program and offers courses in culture and health. These services are broadly utilized by plans and providers in the region.

In general, mainstream plans were acknowledged to have more resources to invest in cultural competency programs, largely because they cover multiple counties and are therefore able to achieve economies of scale. Larger plans were also thought to have invested more in research on the marketing and service aspects of cultural competence. Blue Cross, for example, has a statewide cultural and linguistic program that oversees the planning and implementation of cultural competence within each of the plan's service areas. Kaiser

Foundation Health Plan has established a National Diversity Council and is developing culturally appropriate health services for certain diagnoses and cultural groups. Kaiser has also produced a wide range of educational materials for providers and patients. The National Diversity Council has published a detailed guide for physicians and other providers on health care for the Latino population and will soon issue additional guides for African Americans and other major population groups.[36]

LESSONS LEARNED FROM OTHER STATES: A BRIEF OVERVIEW

State approaches to ensuring Medicaid beneficiaries' access to culturally competent services vary widely. Although partly due to the lack of clear federal guidance, this variation is primarily a result of individual differences among states' demographics and health services delivery systems. Interviews with state Medicaid directors in Washington, Oregon, and Arizona revealed some unique approaches to problems similar to those California is facing.

Washington

Washington, like neighboring Oregon, has a much smaller multiethnic Medicaid population than California; in both states, the non-English-speaking population comprises less than 10 percent of all Medicaid eligibles. Washington is one of only two states that directly reimburses health plans for the cost of translation services for clinical care. Plans cover the cost of interpreter services for members. The state also tests and certifies interpreters. Native Americans are automatically exempted from mandatory enrollment in managed care, although they can enroll in plans operated by tribal clinics.

Oregon

Oregon's Medicaid program, like California's, uses a concentration criterion for requiring linguistic services. It is defined, however, at the provider level: a Medicaid-participating physician who is selected by at least 35 members of a single ethnic group. No direct marketing is allowed. Community organizations and outreach are used to educate beneficiaries about their options, and plan selection rates are very high—less than 10 percent of beneficiaries are assigned to plans by the state. Few detailed contractual requirements exist, although the state is considering requirements for 24-hour access to translation services and other components of the California approach.

Capitation rates include an estimate for plan administrative costs, which are intended to include the costs of translation and interpreter services. Oregon does not provide direct reimbursement for plan costs associated with linguistic services, but the state is currently considering whether to pool these costs and risk-adjust premiums based on differences in language burden across plans.

[36] *A Provider's Handbook on Culturally Competent Care: Latino Population,* prepared by Kaiser Permanente National Diversity Council, Oakland, CA, 1997.

Arizona

Arizona's Medicaid program, which serves a population that is 35 percent Latino, has for 15 years functioned primarily as a managed care program.[37] In response to the substantial increase in health plan competition for Medicaid enrollees in recent years, the program has developed a standardized approach to quality monitoring, including the introduction of a member survey. First fielded in 1996, the survey has reported a very high rate of satisfaction across the entire Medicaid managed care population. Although its findings have not been analyzed by ethnic or linguistic group,[38] satisfaction rates for those counties with high concentrations of Native American and Latino populations have been found to be equally high.[39] Several interviewers commented that the maturity of Arizona's program is an important factor in customer satisfaction: plans and providers know their Medicaid population well, and plans—most of which are locally based—possess strong experience in serving the Native American and Latino populations.

SUMMARY OF KEY FINDINGS

The difficulties of reaching, educating, and enrolling a complex multicultural population in a managed care system that is itself new and still evolving should not be underestimated. This study examined a system with a multitude of new plan and provider services, most of which are as yet largely unevaluated. Nevertheless, several conclusions emerge from this early review.

Medi-Cal contract requirements for cultural competency have had a substantial impact on health plan services and operations.

The Medi-Cal requirements have led plans to add staff and establish training programs and services designed to make health care access easier and health care services more effective for multiethnic populations. Prior to contracting with Medi-Cal, most mainstream plans had addressed minority populations only in the context of marketing. All plan representatives reported that their cultural competency efforts are now supporting plan and provider services for non-Medi-Cal enrollees as well—suggesting that Medi-Cal's strategy was indeed seeding greater cultural competence in plan operations aimed at privately insured populations.

The key effective components of the contract requirements include:

- *Defining criteria for threshold populations.* Because of the great diversity of racial, ethnic, and linguistic groups served by Medi-Cal, plans and providers need a clear definition of the populations and service areas for which specialized services are required. Medi-Cal's threshold and concentration criteria appear to be useful toward this end.

[37] Personal communication with the Arizona Health Care Cost Containment System, 1998.

[38] Summary Report of the 1996 AHCCCS Member Survey conducted by Arizona Health Care Cost Containment System.

[39] Personal communication with John Kelly, Director, AHCCCS, 1998.

- *Translation of plan materials.* Although the process of state approval is apparently cumbersome, it has spurred health plans to make their member services and health education materials uniformly available in languages appropriate to the needs of their members.

- *Complete access to interpreter services.* By requiring plans to provide 24-hour telephone access and establish protocols for the scheduling of interpreters when necessary, Medi-Cal has ensured a baseline availability of language services for beneficiaries.

- *Community participation in plan services development.* The establishment of community advisory committees has provided plan members with an organized framework for representing their needs and reviewing plan services. In addition, health plan staff gain insights from their direct interactions with members.

Other findings stem from health plan implementation of Medi-Cal contract requirements:

- *Development of training programs.* As plan services directors and provider organizations focus on meeting the needs of specific linguistic and cultural groups, administrators have recognized the need for more staff education, and all plans and provider organizations now have training programs. Although these programs have focused initially on linguistic needs, all individuals interviewed commented that they were developing or attempting to identify effective programs dealing with other cultural aspects of health care. This work is being supported by a growing collection of tools and instruments for assessing cultural competence.[40]

- *Use of community health workers.* Not surprisingly, some plans and providers have realized that providing education to members on an ongoing basis and managing chronic disease and prenatal care for non-English-speaking patients can be difficult and time-consuming. This in turn has led to increasing experimentation with the use of community health workers. In light of the limited contact time available between patients and clinical providers in most health care settings today, community health worker programs may offer an effective means of support for the health care management needs of all patients.

- *Use of plan surpluses.* Several of the Medi-Cal local initiatives reported plan surpluses at the end of their first year of operations. Each plan has allocated a part of

[40] M.D. Tirado, "Tools for Monitoring Cultural Competency in Health Care," presentation to Sacramento Department of Health Services, April 1998.

its surplus to community education, risk prevention, and disease management initiatives aimed at non-English-speaking populations.

Provider networks have been expanded to include minority physicians, community health centers, public clinics, and other traditional providers of care to Medi-Cal beneficiaries.

- *Minority physicians and traditional providers.* Medi-Cal policy calls for local initiatives to include traditional providers in their managed care networks. Mainstream health plans were selected in a competitive bidding process that rated the adequacy of provider networks, including representation of traditional providers and provision of appropriate linguistic services. Mainstream plans reported that this process led them to expand their provider networks substantially. A recent study of Medicaid managed care contracting in California found that minority physicians participated at equal rates.[41]

- *Public hospitals and clinics.* Public hospitals have historically been at the forefront in providing interpreter and other services for California's non-English-speaking populations. The Medi-Cal managed care expansion plan proposed the development of local initiatives largely to ensure public and community hospital participation in managed care at levels adequate for these institutions to continue to receive Medicaid disproportionate share payments. The actual effect of this requirement, however, has been to maintain the availability of multicultural services at those hospitals.

Medi-Cal requirements have created a market for vendors of services to support cultural competency and for bilingual employees in health plans and provider organizations.

Community-based organizations, in particular, have benefited from cultural competency requirements. Some have expanded their operations to include interpreter training, interpreter pools, and provider training. These services represent a new source of revenue for community organizations still uncertain of the impact of Medi-Cal managed care on their financial stability. In addition, new employment opportunities within health plans have been created for bilingual staff.

The new requirements point the way toward further reforms to improve patient satisfaction with Medicaid managed care.

While the indicators of progress described above are encouraging, there is no question that the multiethnic populations served by Medi-Cal would benefit from improvements in several

[41] A. Bindman et al., "Selection and Exclusion of Primary Care Physicians by Managed Care Organizations," *Journal of the American Medical Association* 279 (March 4, 1998):675–679.

other important areas. In fact, some of the problems encountered by minority populations are shared by white Anglo Medi-Cal beneficiaries and by those enrolled in private managed care. The Governor's California Managed Care Improvement Task Force, which included representatives of health plans and purchasers as well as providers and consumers, released a report in January 1998 calling for a broad set of reforms. Among them were a new state department to oversee managed care plans, standard information on health plan quality and performance for consumers, an external appeal review process, and pilot testing of risk adjustment for health plan premiums. The task force clearly saw the need to make managed care more responsive to consumers' concerns and thus laid the foundation for future legislative action.

IMPLICATIONS AND RECOMMENDATIONS

California's experience in implementing cultural competency guidelines in Medicaid managed care contracting offers some valuable insights for Medicaid managed care programs throughout the nation. States will need to work with plans and providers to resolve some key operational issues.

States could promote greater quality and efficiency in the provision of culturally competent services by implementing effective contracting guidelines.

- *Simplify the process of producing and approving translations for plan materials.* Health plans participating in Medicaid managed care frequently serve 5 to 10 separate language groups. The sheer quantity of material to be translated and approved by state agencies can introduce delays and complexities that may be avoidable. Plan and provider administrators suggest that states approve organizations and individuals for providing and reviewing translations and eliminate the requirement for subsequent state review. Doing so would minimize possible delays in approval and also allow for variations in dialect within an enrolled population.

- *Issue quality guidelines for interpreter services.* Both health plans and providers urge states to establish clear but flexible definitions of what is adequate with respect to interpreter services. Opinion is mixed on the value of mandatory interpreter certification: plans and providers are principally concerned about cost, but they are also wary of overregulation by the states. Some are familiar with the mandatory certification process in Washington State, where, for certain Asian languages, few native speakers have successfully passed the certification exams. Organizations that support the concept—primarily providers—feel that more specific standards are needed. At the same time, they also argued for a kind of risk adjustment in setting premiums and capitation rates for multilingual services. At a minimum, issuing standards for voluntary interpreter certification would assist organizations that desire guidance as to what constitutes an appropriate level of service.

- *Develop practical tools for the assessment of provider proficiency in other languages.* Most plans are required to assess and report on their own member services staff and on network provider proficiency in non-English languages. Plans report that the lack of a standard set of instruments presents a difficult problem, especially if each plan or provider organization uses a different instrument and clinical providers are subject to multiple tests.

Data systems capable of tracking and providing information about care delivery, differentiated by population characteristics, will be needed to identify the specific health needs of multicultural populations and to assess the competence of the plans and providers serving them.

For this study, we proposed a measure of cultural competence in managed care that focuses on the outcome of a health care encounter, episode of care, or overall membership in a health plan with regard to patient satisfaction, health status, and cost-effectiveness. We found, however, that California's and other states' Medicaid programs did not yet have the information by which the quality of care could be assessed and areas for improvement identified. Quality and oversight are especially important when low-income, culturally diverse populations are moving to a health care system based on limited choice.[42]

- *Assess the validity of demographic databases used by state Medicaid managed care programs and departments.* Most states have implemented some type of database that collects information on Medicaid beneficiaries regarding race, ethnicity, and language preference; in California, the MEDS database serves this function. Studies on the validity of these databases are urgently needed. If the data are determined to be of acceptable quality, then health plans, providers, and researchers could proceed with evaluations of services provided and consumer satisfaction by race/ethnicity and language group. Currently, such evaluations are very sporadic and are difficult to implement effectively across plans. If the data are unusable and cannot be improved, then other approaches, including targeted surveys and research, should be undertaken.

- *Assess the validity and utility of the information collected in the initial patient assessments.* Most states that have already implemented Medicaid managed care have some provision requiring or encouraging beneficiaries to see a primary care provider within a certain number of days following enrollment. In California, Medi-Cal managed care beneficiaries are supposed to schedule their visit within the first 120 days of enrollment. Presumably, information about race/ethnicity and linguistic needs collected in this setting is more reliable than that volunteered by beneficiaries during the eligibility determination process. Little has been done, however, to test such matters as the cost and difficulty of gathering these data in states that collect demographic information during the first PCP visit.

[42] R. Lavizzo-Mourey and E.R. Mackenzie, "Cultural Competence: Essential Measurements of Quality for Managed Care Organizations," *Annals of Internal Medicine* 124 (10):919–921.

- *Link race/ethnicity and linguistic group to utilization patterns in Medicaid managed care.* This will be a substantial and initially complex task, as most states are not yet able to collect encounter-level data from managed care providers in a reliable and systematic way. One California contractor, MedStat, has been working with the state to design a method for collecting these data, but state officials are uncertain about plans' ability to use the system. A study should be considered to examine how other states are addressing these data needs and what alternative approaches can effectively link race, ethnicity, and linguistic need to care utilization patterns.

- *Evaluate the additional cost of providing care to multicultural and non-English-speaking populations.* Preliminary studies have identified variations (adjusted for age and sex) in costs between Medicaid and commercially insured enrollees in managed care plans.[43] The impact of cultural competency provisions has not been calculated. As providers and plans become more experienced in analyzing the cost of services under managed care, they will be able to parse out the incremental cost of translations, interpreter services, extended office visits, training for health professionals, and other culturally competent services. Oregon and a few other states are considering using risk adjustment in reimbursing plans for these costs. In California, experiments with risk adjustment for commercially insured populations—adjusting for the burden of disease and injury, but not for linguistic needs—may begin in 1999. Inclusion of cultural and linguistic service needs as a risk adjuster in Medicaid rates has not been proposed by most states.

- *Achieve as much consistency as possible in services provided through state-financed health care programs.* Many states have numerous publicly financed programs that serve similar populations yet use different requirements and methods of implementation. California, for example, will not apply all Medi-Cal managed care cultural competence requirements to its Healthy Families child health insurance program. A number of other states have mental health and other Medicaid managed care carve-outs that vary from the state Medicaid managed care program. Attempts should be made wherever possible to rationalize requirements across publicly financed programs.

A substantial caveat should be appended to this discussion. Owing to the brief periods during which many beneficiaries are eligible for Medicaid, attempts to correlate utilization and outcomes with the quality of cultural and linguistic services provided by health plans and providers may be misleading. In fact, it may be more correct to undertake studies of this type to characterize *existing variations* in the patterns of morbidity and health

[43] W.P. Welch and M. Wade, "The Relative Cost of Medicaid Enrollees and the Commercially Insured in HMOs," *Health Affairs* 14 (2):212–223.

services utilization in multicultural populations. Over time, an adequate method for collecting information on access, quality, and satisfaction may allow states to discriminate among plans and providers.

Experimentation and innovation in culturally competent care by health plans and providers has yet to be evaluated and captured adequately. A common system for evaluating quality across plans and providers would reduce the tendency to reinvent the wheel. Providers and plan administrative staff frequently reported that they were interested in implementing innovative programs that they knew of in their state or elsewhere in the country. However, they did not know how the programs had been implemented or whether they had been successful. Efforts to gather information on various programs, evaluate them, and provide technical assistance to programs wishing to adopt specific approaches would help expand the provision of multicultural health services in California and other states. Providers and plans mentioned the need for "best practices" or practice guidelines for member services, health education, and patient care.

National accreditation programs for managed care providers should include a cultural competence component by which differences in process and outcomes measures by racial/ethnic or linguistic group can be examined. Harvard Medical School, the RAND Corporation, and the Research Triangle Institute developed the Consumer Assessment of Health Plans Survey (CAHPS) for the Agency for Health Care Policy and Research (AHCPR). The National Committee for Quality Assurance is working with AHCPR to achieve integration of parts of CAHPS into the Health Plan Employer Data and Information Set (HEDIS). This is an important step, because it will support the routine collection of information on race/ethnicity and language and introduce a practical means of assessing relative cultural competence among plans and providers. Efforts to expand this initiative and to support plans and providers in responding to it should be encouraged.

Medicaid contract requirements have had a substantial impact on health plan services and operations, yet efforts to provide culturally competent services linked to patients' health status and health outcomes are still in their infancy. One of the primary barriers to implementation of culturally competent services is lack of data. Efforts need to be initiated to develop and validate meaningful tools to assess the specific health needs of multicultural populations as well as providers' and plans' ability to meet these needs. National accreditation programs for managed care providers should be encouraged to support measures of cultural competence that differentiate outcome measures by race, ethnicity, and language. As more states turn to risk adjustment for setting insurance premiums, the evaluation of culturally competent services will become increasingly important.

APPENDIX A

LIST OF ORGANIZATIONS INTERVIEWED

Alliance for Health of Alameda County
Alameda County, California

Alameda Health Consortium/
Community Health Center Network
Alameda County, California

Asian Health Services
Oakland, California

Blue Cross of California
Cultural and Linguistic Programs
Camarillo, California

State of California Department of
Health Services
Medi-Cal Managed Care Division
(Policy and Quality Improvement Branch)
Health Coordination Unit
Sacramento, California

The California Endowment
Woodland Hills, California

Foundation Health
Pasadena, California

Joint Center for Political and
Economic Studies
Washington, DC

Latino Coalition for a Healthy California
San Francisco, California

LA Care Healthplan
Los Angeles, California

County of San Diego, Health and Human
Services Agency
San Diego, California

Arizona Health Care Cost
Containment System
Tempe, Arizona

Office of Medical Assistance Programs
Eugene, Oregon

Department of Social and Health Services
Olympia, Washington

Partnership Healthplan of California
Suisun City, California

UHP Healthcare
Inglewood, California

APPENDIX B

CASE STUDY OF ALLIANCE FOR HEALTH OF ALAMEDA COUNTY

In Alameda County, which includes the city of Oakland, two plans serve Medi-Cal beneficiaries: the local initiative, known as Alliance for Health, which has operated since January 1996 and currently serves 62,000 members; and Blue Cross of California, which began operating there in July 1996 and currently serves 26,000 Medi-Cal beneficiaries. Alliance for Health was the first local initiative in the state to begin operating in the two-plan model. In its second year of operation, Alliance for Health had a total budget of approximately $70 million.

Alliance for Health has held its own in marketing through aggressive community outreach and use of an open network that contracts with all interested traditional providers who previously served Medi-Cal patients. Although numbers for default enrollment rates are not available for the first year of operation, 1997 figures support the strength of their efforts. A three-month sample shows a decline in default rates for Alliance for Health from 27 percent in March 1997 to 12.6 percent by May 1997.[44] At the same time, Alliance for Health has brought many physicians who were high-volume Medi-Cal fee-for-service providers into managed care for the first time. Although some had previously belonged to independent practice associations that held managed care contracts, most did not have any appreciable volume of patients under these contracts.

Alameda's local initiative sends interpreters, on request and without charge, to private providers' offices. The county plan has contracted with Asian Health Services, a large community health center, to establish a pool of interpreters for the plan and for local providers and to design and offer a training program for the interpreters. Asian Health Services also offers courses for health providers on how to use interpreters effectively. Alliance for Health intends to reward providers for appropriate use of interpreters as a part of the risk-sharing incentives.

To address the cultural aspects of care beyond linguistic services, the Children's Hospital Oakland instituted training programs and workshops for providers on cultural beliefs, expectations, and behavior in health. Medi-Cal managed care providers have been interested in learning who the likely decision-makers on health matters are within families, how to interact effectively with families, and what the health beliefs and expectations of each cultural group are.

[44] Personal communication with Alliance for Health of Alameda County, April 1998, supported Health Care Options' Monthly Enrollment Summaries.

The community advisory committee established by Alliance for Health has broad involvement in the development and implementation of services for the plan. Over the past two years, the committee has: (1) provided input on all plans for cultural and linguistic services, including all translations of materials; (2) helped design the group needs assessment, including focus group recruitment and the identification of community resources; (3) provided the Alliance with input on creating an ombudsman program for Medi-Cal beneficiaries enrolled in managed care; and (4) served as a liaison with community organizations and advocacy groups. In addition, the committee reviewed plans for the first satisfaction survey. Its suggestions led to the development of the Neighbor to Neighbor Survey Project, which enlists, trains, and pays welfare recipients to serve as community field workers conducting member satisfaction surveys over the phone and in household visits. Of the 490 surveys conducted, 66 percent were in languages other than English.[45]

Anticipating that improved access to primary care would decrease expensive trends in utilization, the leadership of Alliance for Health established a community health investment fund to reinvest some of the expected savings in community health programs. In the first year, $1.5 million was allocated to the fund, of which $1.2 million will be awarded as grants to community organizations providing indigent care or partnering in programs to improve community health. The remaining $300,000 will be used to seed the development of new programs in high-need areas.

Interviews with Alliance for Health administrators have suggested that analytic efforts to identify access and utilization problems related to language and racial/ethnic groups have begun. The Alliance is also implementing clinical care management programs for diabetes and pregnancy for the African American Medi-Cal population and hopes to expand disease management as an area of concentration for its cultural competency program.

[45] Personal communication with Alliance for Health of Alameda County, April 9, 1998.

APPENDIX C

STATUS OF MEDI-CAL MANAGED CARE ENROLLMENT IN TWO-PLAN MODEL COUNTIES IN CALIFORNIA

As of December 1997, 12 county local initiatives had enrolled approximately 624,272 members and four mainstream health plans participating in Medi-Cal had enrolled 472,160 members (see Table 2). The two largest mainstream (commercial) plan provider are Foundation Health, with 239,677 enrollees in Los Angeles County alone, and Blue Cross of California, the mainstream provider in Alameda, Fresno, Kern, San Francisco, and Santa Clara counties, with over 190,775 members as reported by the California Department of Health Services.

Table 2. December 1997 Monthly Enrollment

County	Health Plans	Plan Type	Enrollment
Alameda	Alameda Alliance for Health	LI	68,652
	Blue Cross of California	CP	23,971
			92,623
Contra Costa	Contra Costa Health Plan	LI	39,280
	Foundation Health	CP	3,772
			43,052
Fresno	Foundation Health	CP	14,846
	Blue Cross of California	CP	97,151
			111,997
Kern	Kern Family Health Care	LI	52,324
	Blue Cross of California	CP	23,955
			76,275
Los Angeles	LA Care	LI	181,742
	Foundation Health	CP	239,677
	1 PCCM contract		400
			421,819
Riverside and	Inland Empire Health Plan	LI	131,587
San Bernardino	Molina Medical Centers	CP	N/A
	5 PCCM contracts		43,635
			175,222
San Francisco	San Francisco Health Authority	LI	20,659
	Blue Cross of California	CP	14,389
			35,048
San Joaquin	Health Plan of San Joaquin	LI	55,667
	Omni Health Care	CP	11,586
			67,253

Santa Clara	Santa Clara Family Health Plan	LI	37,323
	Blue Cross of California	CP	31,309
			65,632
Stanislaus	Stanislaus County Health Plan*	LI	22,192
	Omni Health Care	CP	26,350
			48,542
Tulare	MediCo	LI	N/A
	Foundation Health	CP	N/A

LI = local initiative
CP = commercial plan
PCCM = primary care case management

* Operated by Blue Cross of California.

Source: Status of Managed Care Medi-Cal, Managed Care Division Summary by County, California Department of Health Services, January 1998.