

**DEPARTMENT OF MANAGED HEALTH CARE  
OFFICE OF PLAN MONITORING  
DIVISION OF PLAN SURVEYS**

**TECHNICAL ASSISTANCE GUIDE**

**LANGUAGE ASSISTANCE PROGRAM**

**ROUTINE DENTAL SURVEY**

**OF**

**PLAN NAME**

**(A Medi-Cal Dental Managed Care Plan)**

**DATE OF SURVEY:**

**PLAN COPY**

*Issuance of this January 15, 2016 Technical Assistance Guide renders all other versions obsolete.*

# **LANGUAGE ASSISTANCE TAG**

## **LANGUAGE ASSISTANCE PROGRAM**

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## Requirement LA-001: Language Assistance Policies and Procedures

### STATUTORY/REGULATORY CITATIONS

#### **Health and Safety Code section 1367.04(a)**

(a) Not later than January 1, 2006, the Department shall develop and adopt regulations establishing standards and requirements to provide health care service plan enrollees with appropriate access to language assistance in obtaining health care services.

#### **28 CCR 1300.67.04(a)(1)**

(a) Application.

(1) Every health care service plan, including specialized health care service plans (plans) shall comply with the requirements of this section. The requirements of this section shall not apply to plan contracts for the provision of services to Medi-Cal enrollees or to contracts between plans and the federal government for the provision of service to Medicare enrollees.

#### **28 CCR 1300.67.04(c)**

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

#### **28 CCR 1300.67.04(e)(2)**

(e) Implementation.

(2) By July 1, 2009, every plan shall have established and implemented a language assistance program in compliance with the requirements of section 1367.04 of the Act and this section.

#### **28 CCR 1300.67.04(f)**

(f) The Department will periodically review plan compliance with the standards and requirements of section 1367.04 of the Act and this section by methods that may include, but are not limited to, the medical survey process, reviews of consumer grievances and complaints to the Department's HMO Help Center, and provider complaints submitted to the Department's provider complaint line. The Department may also periodically request that plans submit information and data regarding enrollee language needs and demographic profile.

**INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED**

**Staff responsible for the activities described above, for example:**

- Director of Quality Management Program and/or the executive with overall responsibility for the Plan’s Language Assistance Program (LAP)
- Director of Operations
- Manager of Member/Customer Services
- Director of Provider Networks or contracting

**DOCUMENTS TO BE REVIEWED**

- The Plan’s Language Assistance (LA) Program and/or LA policies and procedures, including:
  - Language assistance services (including translation and interpretation)
  - Language assistance staff training
  - Language Assistance Program compliance monitoring
  - The Plan’s policies and procedures for informing enrollees of the availability of Language assistance services
- The job description of the individual(s) or committee(s) with overall responsibility for the Language Assistance (LA) Program

**LA-001 - Key Element 1:**

1. The Plan has a written description of, or policies and procedures describing the Language Assistance Program.  
28 CCR 1300.67.04(c); 28 CCR 1300.67.04(e)(2); 28 CCR 1300.67.04(f)

Assessment Questions	Yes	No	N/A	Go to Comments
1.1 Does the scope of the LA Program address standards for <b>language assistance services</b> ?				<a href="#">Click</a>
1.2 Does the scope of the LA Program address standards for language assistance <b>staff training</b> ?				<a href="#">Click</a>
1.3 Does the scope of the LA Program address standards for Language Assistance Program <b>compliance monitoring</b> ?				<a href="#">Click</a>

**End of Requirement LA-001: Language Assistance Policies and Procedures**

## Requirement LA-002: Enrollee Assessment

### STATUTORY/REGULATORY CITATIONS

#### **CA Health and Safety Code section 1367.04(b)**

(b) In developing the regulations, the department shall require every health care service plan and specialized health care service plan to assess the linguistic needs of the enrollee population, excluding Medi-Cal enrollees, and to provide for translation and interpretation for medical services, as indicated. A health care service plan that participates in the Healthy Families Program may assess the Healthy Families Program enrollee population separately from the remainder of its enrollee population for purposes of subparagraph (A) of paragraph (1). A health care service plan that chooses to separate its Healthy Families Program enrollment from the remainder of its enrollee population shall treat the Healthy Families Program population separately for purposes of determining whether subparagraph (A) of paragraph (1) is applicable, and shall also treat the Healthy Families Program population separately for purposes of applying the percentage and numerical thresholds in subparagraph (A) of paragraph (1). The regulations shall include the following:

(1) Requirements for the translation of vital documents that include the following:

(A) A requirement that all vital documents, as defined pursuant to subparagraph (B), be translated into an indicated language, as follows:

(i) A health care service plan with an enrollment of 1,000,000 or more shall translate vital documents into the top two languages other than English as determined by the needs assessment as required by this subdivision and any additional languages when 0.75 percent or 15,000 of the enrollee population, whichever number is less, excluding Medi-Cal enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language.

(ii) A health care service plan with an enrollment of 300,000 or more but less than 1,000,000 shall translate vital documents into the top one language other than English as determined by the needs assessment as required by this subdivision and any additional languages when 1 percent or 6,000 of the enrollee population, whichever number is

less, excluding Medi-Cal enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language.

(iii) A health care service plan with an enrollment of less than 300,000 shall translate vital documents into a language other than English when 3,000 or more or 5 percent of the enrollee population, whichever number is less, excluding Medi-Cal enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language.

(B) Specification of vital documents produced by the plan that are required to be translated. The specification of vital documents shall not exceed that of the Department of Health and Human Services (HHS) Office of Civil Rights (OCR) Policy

Guidance (65 Federal Register 52762 (August 30, 2000)), but shall include all of the following:

- (i) Applications.
  - (ii) Consent forms.
  - (iii) Letters containing important information regarding eligibility and participation criteria.
  - (iv) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal.
  - (v) Notices advising limited-English-proficient persons of the availability of free language assistance and other outreach materials that are provided to enrollees.
  - (vi) Translated documents shall not include a health care service plan's explanation of benefits or similar claim processing information that is sent to enrollees, unless the document requires a response by the enrollee.
- (C)(i) For those documents described in subparagraph (B) that are not standardized but contain enrollee specific information, health care service plans shall not be required to translate the documents into the threshold languages identified by the needs assessment as required by this subdivision, but rather shall include with the documents a written notice of the availability of interpretation services in the threshold languages identified by the needs assessment as required by this subdivision.
- (ii) Upon request, the enrollee shall receive a written translation of the documents described in clause (i). The health care service plan shall have up to, but not to exceed, 21 days to comply with the enrollee's request for a written translation. If an enrollee requests a translated document, all timeframes and deadline requirements related to the document that apply to the health care service plan and enrollees under the provisions of this chapter and under any regulations adopted pursuant to this chapter shall begin to run upon the health care service plan's issuance of the translated document.
- (iii) For grievances that require expedited plan review and response in accordance with subdivision (b) of Section 1368.01, the health care service plan may satisfy this requirement by providing notice of the availability and access to oral interpretation services.
- (D) A requirement that health care service plans advise limited-English-proficient enrollees of the availability of interpreter services.
- (2) Standards to ensure the quality and accuracy of the written translations and that a translated document meets the same standards required for the English language version of the document. The English language documents shall determine the rights and obligations of the parties, and the translated documents shall be admissible in evidence only if there is a dispute regarding a substantial difference in the material terms and conditions of the English language document and the translated document.
- (3) Requirements for surveying the language preferences and needs assessments of health care service plan enrollees within one year of the effective date of the regulations that permit health care service plans to utilize various survey methods, including, but not limited to, the use of existing enrollment and renewal processes, subscriber newsletters, or other mailings. Health care service plans shall update the needs assessment, demographic profile, and language translation requirements every three years.
- (4) Requirements for individual enrollee access to interpretation services.

(5) Standards to ensure the quality and timeliness of oral interpretation services provided by health care service plans..

**28 CCR 1300.67.04(b)(1), (2), (5), and (6)**

(b) Definitions.

(1) Demographic profile means, at a minimum, identification of an enrollee's preferred spoken and written language, race, and ethnicity.

(2) Interpretation: the act of listening to something spoken or reading something written in one language (source language) and orally expressing it accurately and with appropriate cultural relevance into another language (target language).

(5) Threshold Language(s): the language(s) identified by a plan pursuant to Section 1367.04(b)(1)(A) of the Act.

(6) Translation: replacement of a written text from one language (source language) with an equivalent written text in another language (target language).

**28 CCR 1300.67.04(c)(1)(A), (B), and (C)**

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

(1) Enrollee Assessment. Every health care service plan and specialized health care service plan shall assess its enrollee population to develop a demographic profile and to survey the linguistic needs of individual enrollees. In assessing its enrollee population each plan shall, at a minimum:

(A) Develop a demographic profile of the plan's enrollee population for the purposes of calculating threshold languages and reporting to the Department pursuant to Section 1367.07 of the Act. All plans shall apply statistically valid methods for population analysis in developing the demographic profile and plans may utilize a variety of methods for collecting demographic data for this purpose, including census data, client utilization data from third parties, data from community agencies and third party enrollment processes;

(B) Survey its enrollees in a manner designed to identify the linguistic needs of each of the plan's enrollees, and record the information provided by a responding enrollee in the enrollee's file. Plans may utilize existing processes and methods to distribute the linguistic needs survey, including but not limited to, existing enrollment and renewal processes, subscriber newsletters, mailings and other communication processes. A plan may demonstrate compliance with the survey requirement by distributing to all subscribers, including all individual subscribers under group contracts, a disclosure explaining, in English and in the plan's threshold languages, the availability of free language assistance services and how to inform the plan and relevant providers regarding the preferred spoken and written languages of the subscriber and other enrollees under the subscriber contract; and

(C) Collect, summarize and document enrollee demographic profile data in a manner that enables the plan to maintain confidentiality of personal information and to disclose the information to the Department on request for regulatory purposes and to contracting providers on request for lawful purposes, including language assistance purposes and health care quality improvement purposes. This section is not intended to limit or expand existing law regarding confidentiality of medical records.

**28 CCR 1300.67(c)(2)(F)(ii)**

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

(F) Processes and standards for providing translation services, including, but not limited to:

(ii) A list of the types of standardized and enrollee-specific vital documents that must be translated and the applicable standards for making translated vital documents available to subscribers and enrollees. Plans need not translate subscriber contracts, evidences of coverage and other large disclosure forms and enrollee handbooks in their entirety, but may excerpt from large documents the disclosures specified at subsection (b)(7)(G) for translation in a format that permits cost-effective and timely production and distribution, so long as there is no loss of accuracy or meaning by doing so. A plan may demonstrate compliance regarding translation of the disclosures specified at subsection (b)(7)(G) if the plan provides a standardized matrix that lists the major categories of health care services covered under the plan's subscriber contracts, together with the corresponding copayments and coinsurance, and exclusions and limitations, and disclosing any applicable deductibles and lifetime maximums, using the same sequence as the uniform matrix described at Section 1363(b)(1) of the Act.

**28 CCR 1300.67.04(e)(1)**

(e) Implementation.

(1) Within one year of the effective date of this section, every plan shall complete the initial enrollee assessment required by Section 1367.04 of the Act and this section. Every plan shall update its assessment of enrollee language needs and enrollee demographic profile at least once every three years following the initial assessment.

**INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED**

**Staff responsible for the activities described above, for example:**

- Director of Quality Management or Executive with overall responsibility for the Plan's LA Program

**DOCUMENTS TO BE REVIEWED**

- Policies and procedures relating to the enrollee assessment and survey processes
- Data sources for completing the demographic profile
- The Plan’s demographic profile and language needs assessment (report or other documentation)
- Evidence of statistical analysis of the demographic data
- Enrollee linguistic needs survey
- Disclosure or notice to enrollees regarding the availability of LA services

**LA-002 - Key Element 1:**

**1. The Plan has standards for the enrollee assessment and has completed an assessment of the linguistic needs of its enrollee population and developed a demographic profile.**

**CA Health and Safety Code section 1367.04(b)(1); 28 CCR 1300.67.04(c)(1)(A), (B), and (C); 28 CCR 1300.67.04(e)(1)**

<b>Assessment Questions</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
The Plan has standards and a policy for completing an enrollee language needs assessment and demographic profile.			
1.1 Did the Plan develop a demographic profile of the enrollee population?			
1.2 Does the Plan demonstrate that statistically valid methods for population analysis were applied in developing the demographic profile?			
1.3 Has the Plan defined the process for updating the demographic profile data at least every three years?			
1.4 Has the Plan defined a list of the non-English languages likely to be encountered among the Plan’s enrollees?			
1.5 Has the Plan completed an update of its assessment of enrollee language needs and enrollee demographic profile at least once every three years following the initial assessment?			

**LA-002 - Key Element 2:**

**2. The Plan demonstrates that it has assessed the linguistic needs of the Plan’s enrollees by surveying enrollees and/or distributing a disclosure.**

**CA Health and Safety Code section 1367.04(b); 28 CCR 1300.67.04(c)(1)(B)**

Assessment Questions	Yes	No	N/A
2.1 Has the Plan surveyed enrollees in a manner designed to identify the linguistic needs of each of the Plan's enrollees?			
2.2 Does the Plan record the information provided by a responding enrollee in the enrollee's file?			
2.3 <b>If the Plan did not send a linguistic needs survey to each enrollee</b> , has the Plan distributed a disclosure or notice (to all subscribers) regarding the availability of free language assistance services, and how to inform the Plan and relevant providers regarding the preferred spoken and written language of the subscriber and other enrollees under the subscriber contract?			
2.4 Is the notice in English and the Plan's threshold languages?			
2.5 Does the notice state that the Language Assistance services were free?			

**LA-002 - Key Element 3:**

**3. The Plan has identified its threshold or indicated language(s) consistent with section 1367.04(b)(1).  
CA Health and Safety code section 1367.04(b)(1)(A)**

Assessment Questions	Yes	No	N/A
3.1 Has the Plan identified a threshold language(s) based on the statutory formula noted in section 1367.04(b)(1)(A)? <b>If yes</b> , go to Key Element 4. <b>If no</b> , go to Requirement 003 (LA Services).			

**LA 002 – Key Element 4:**

**4. The Plan has translated vital documents into threshold languages as required.  
CA Health and Safety Code sections 1367.04(b)(1)(B) and (C); 28 CCR 1300.67.04(c)(1)(A); 28 CCR 1300.67.04(c)(2)(F)(ii)**

Assessment Questions	Yes	No	N/A
4.1 Has the Plan specified the standardized vital documents that must be translated? (And does the list meet statutory requirements?)			
4.2 Has the Plan translated the specified standardized vital documents into threshold languages?			

**End of Requirement LA-002: Enrollee Assessment**

## Requirement LA-003: Language Assistance Services

### STATUTORY/REGULATORY CITATIONS

#### **CA Health and Safety code 1363(b)(1)**

(b)(1) As of July 1, 1999, the director shall require each plan offering a contract to an individual or small group to provide with the disclosure form for individual and small group plan contracts a uniform health plan benefits and coverage matrix containing the plan's major provisions in order to facilitate comparisons between plan contracts. The uniform matrix shall include the following category descriptions together with the corresponding co-payments and limitations in the following sequence:

- (A) Deductibles.
- (B) Lifetime maximums.
- (C) Professional services.
- (D) Outpatient services.
- (E) Hospitalization services.
- (F) Emergency health coverage.
- (G) Ambulance services.
- (H) Prescription drug coverage.
- (I) Durable medical equipment.
- (J) Mental health services.
- (K) Chemical dependency services.
- (L) Home health services.
- (M) Other.

#### **CA Health and Safety Code 1367.04(b)(1)(B)(iii) and (v)**

(b) In developing the regulations, the department shall require every health care service plan and specialized health care service plan to assess the linguistic needs of the enrollee population, excluding Medi-Cal enrollees, and to provide for translation and interpretation for medical services, as indicated. A health care service plan that participates in the Healthy Families Program may assess the Healthy Families Program enrollee population separately from the remainder of its enrollee population for purposes of subparagraph (A) of paragraph (1). A health care service plan that chooses to separate its Healthy Families Program enrollment from the remainder of its enrollee population shall treat the Healthy Families Program population separately for purposes of determining whether subparagraph (A) of paragraph (1) is applicable, and shall also treat the Healthy Families Program population separately for purposes of applying the percentage and numerical thresholds in subparagraph (A) of paragraph (1). The regulations shall include the following:

(B) Specification of vital documents produced by the plan that are required to be translated. The specification of vital documents shall not exceed that of the Department of Health and Human Services (HHS) Office of Civil Rights (OCR) Policy Guidance (65 Federal Register 52762 (August 30, 2000)), but shall include all of the following:

- (iii) Letters containing important information regarding eligibility and participation criteria.
- (v) Notices advising limited-English-proficient persons of the availability of free language assistance and other outreach materials that are provided to enrollees.

**CA Health and Safety section 1368**

- (a) Every plan shall do all of the following:
  - (1) Establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan. Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.
  - (2) Inform its subscribers and enrollees upon enrollment in the plan and annually thereafter of the procedure for processing and resolving grievances. The information shall include the location and telephone number where grievances may be submitted.
  - (3) Provide forms for grievances to be given to subscribers and enrollees who wish to register written grievances. The forms used by plans licensed pursuant to Section 1353 shall be approved by the director in advance as to format.
  - (4) (A) Provide for a written acknowledgment within five calendar days of the receipt of a grievance, except as noted in subparagraph (B). The acknowledgment shall advise the complainant of the following:
    - (i) That the grievance has been received.
    - (ii) The date of receipt.
    - (iii) The name of the plan representative and the telephone number and address of the plan representative who may be contacted about the grievance.(B) Grievances received by telephone, by facsimile, by e-mail, or online through the plan's Internet Web site pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:
    - (i) The date of the call.
    - (ii) The name of the complainant.
    - (iii) The complainant's member identification number.
    - (iv) The nature of the grievance.
    - (v) The nature of the resolution.
    - (vi) The name of the plan representative who took the call and resolved the grievance.
  - (5) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

(6) For grievances involving the cancellation, rescission, or nonrenewal of a health care service plan contract, the health care service plan shall continue to provide coverage to the enrollee or subscriber under the terms of the health care service plan contract until a final determination of the enrollee's or subscriber's request for review has been made by the health care service plan or the director pursuant to Section 1365 and this section. This paragraph shall not apply if the health care service plan cancels or fails to renew the enrollee's or subscriber's health care service plan contract for nonpayment of premiums pursuant to paragraph (1) of subdivision (a) of Section 1365.

(7) Keep in its files all copies of grievances, and the responses thereto, for a period of five years.

(b) (1) (A) After either completing the grievance process described in subdivision (a), or participating in the process for at least 30 days, a subscriber or enrollee may submit the grievance to the department for review. In any case determined by the department to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, cancellations, rescissions, or the nonrenewal of a health care service plan contract, or in any other case where the department determines that an earlier review is warranted, a subscriber or enrollee shall not be required to complete the grievance process or to participate in the process for at least 30 days before submitting a grievance to the department for review.

(B) A grievance may be submitted to the department for review and resolution prior to any arbitration.

(C) Notwithstanding subparagraphs (A) and (B), the department may refer any grievance that does not pertain to compliance with this chapter to the State Department of Public Health, the California Department of Aging, the federal Health Care Financing Administration, or any other appropriate governmental entity for investigation and resolution.

(2) If the subscriber or enrollee is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the subscriber or enrollee, as appropriate, may submit the grievance to the department as the agent of the subscriber or enrollee. Further, a provider may join with, or otherwise assist, a subscriber or enrollee, or the agent, to submit the grievance to the department. In addition, following submission of the grievance to the department, the subscriber or enrollee, or the agent, may authorize the provider to assist, including advocating on behalf of the subscriber or enrollee. For purposes of this section, a "relative" includes the parent, stepparent, spouse, adult son or daughter, grandparent, brother, sister, uncle, or aunt of the subscriber or enrollee.

(3) The department shall review the written documents submitted with the subscriber's or the enrollee's request for review, or submitted by the agent on behalf of the subscriber or enrollee. The department may ask for additional information, and may hold an informal meeting with the involved parties, including providers who have joined in submitting the grievance or who are otherwise assisting or advocating on behalf of the subscriber or enrollee. If after reviewing the record, the department concludes that the grievance, in whole or in part, is eligible for review under the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department shall immediately notify the subscriber or

enrollee, or agent, of that option and shall, if requested orally or in writing, assist the subscriber or enrollee in participating in the independent medical review system.

(4) If after reviewing the record of a grievance, the department concludes that a health care service eligible for coverage and payment under a health care service plan contract has been delayed, denied, or modified by a plan, or by one of its contracting providers, in whole or in part due to a determination that the service is not medically necessary, and that determination was not communicated to the enrollee in writing along with a notice of the enrollee's potential right to participate in the independent medical review system, as required by this chapter, the director shall, by order, assess administrative penalties. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice of, and the opportunity for, a hearing with regard to the person affected in accordance with Section 1397. The administrative penalties shall not be deemed an exclusive remedy available to the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(5) The department shall send a written notice of the final disposition of the grievance, and the reasons therefore, to the subscriber or enrollee, the agent, to any provider that has joined with or is otherwise assisting the subscriber or enrollee, and to the plan, within 30 calendar days of receipt of the request for review unless the director, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. In any case not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department's written notice shall include, at a minimum, the following:

(A) A summary of its findings and the reasons why the department found the plan to be, or not to be, in compliance with any applicable laws, regulations, or orders of the director.

(B) A discussion of the department's contact with any medical provider, or any other independent expert relied on by the department, along with a summary of the views and qualifications of that provider or expert.

(C) If the enrollee's grievance is sustained in whole or in part, information about any corrective action taken.

(6) In any department review of a grievance involving a disputed health care service, as defined in subdivision (b) of Section 1374.30, that is not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), in which the department finds that the plan has delayed, denied, or modified health care services that are medically necessary, based on the specific medical circumstances of the enrollee, and those services are a covered benefit under the terms and conditions of the health care service plan contract, the department's written notice shall do either of the following:

(A) Order the plan to promptly offer and provide those health care services to the enrollee.

(B) Order the plan to promptly reimburse the enrollee for any reasonable costs associated with urgent care or emergency services, or other extraordinary and compelling health care services, when the department finds that the enrollee's decision to secure those services outside of the plan network was reasonable under the circumstances.

The department's order shall be binding on the plan.

(7) Distribution of the written notice shall not be deemed a waiver of any exemption or privilege under existing law, including, but not limited to, Section 6254.5 of the Government Code, for any information in connection with and including the written notice, nor shall any person employed or in any way retained by the department be required to testify as to that information or notice.

(8) The director shall establish and maintain a system of aging of grievances that are pending and unresolved for 30 days or more that shall include a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more.

(9) A subscriber or enrollee, or the agent acting on behalf of a subscriber or enrollee, may also request voluntary mediation with the plan prior to exercising the right to submit a grievance to the department. The use of mediation services shall not preclude the right to submit a grievance to the department upon completion of mediation. In order to initiate mediation, the subscriber or enrollee, or the agent acting on behalf of the subscriber or enrollee, and the plan shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The department shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

(c) The plan's grievance system shall include a system of aging of grievances that are pending and unresolved for 30 days or more. The plan shall provide a quarterly report to the director of grievances pending and unresolved for 30 or more days with separate categories of grievances for Medicare enrollees and Medi-Cal enrollees. The plan shall include with the report a brief explanation of the reasons each grievance is pending and unresolved for 30 days or more. The plan may include the following statement in the quarterly report that is made available to the public by the director:

"Under Medicare and Medi-Cal law, Medicare enrollees and Medi-Cal enrollees each have separate avenues of appeal that are not available to other enrollees. Therefore, grievances pending and unresolved may reflect enrollees pursuing their Medicare or Medi-Cal appeal rights."

If requested by a plan, the director shall include this statement in a written report made available to the public and prepared by the director that describes or compares grievances that are pending and unresolved with the plan for 30 days or more. Additionally, the director shall, if requested by a plan, append to that written report a brief explanation, provided in writing by the plan, of the reasons why grievances described in that written report are pending and unresolved for 30 days or more. The director shall not be required to include a statement or append a brief explanation to a written report that the director is required to prepare under this chapter, including Sections 1380 and 1397.5.

(d) Subject to subparagraph (C) of paragraph (1) of subdivision (b), the grievance or resolution procedures authorized by this section shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the procedures described in this section shall not preclude the use of any other remedy provided by law.

(e) Nothing in this section shall be construed to allow the submission to the department of any provider grievance under this section. However, as part of a provider's duty to advocate for medically appropriate health care for his or her patients pursuant to Sections 510 and 2056 of the Business and Professions Code, nothing in

this subdivision shall be construed to prohibit a provider from contacting and informing the department about any concerns he or she has regarding compliance with or enforcement of this chapter.

(f) To the extent required by Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations, there shall be an independent external review pursuant to the standards required by the United States Secretary of Health and Human Services of a health care service plan's cancellation, rescission, or nonrenewal of an enrollee's or subscriber's coverage.

**28 CCR 1300.67.4(b)(1)(C)**

(b) Definitions.

(1) Demographic profile means, at a minimum, identification of an enrollee's preferred spoken and written language, race and ethnicity.

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

**28 CCR 1300.67.04(c)(2)(C), (D), (E), (F), (G) and (H)**

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

(2) Providing Language Assistance Services. Every plan shall develop language assistance program policies and procedures, which shall describe, at a minimum, the information outlined below.

(C) The plan's processes for informing enrollees of the availability of language assistance services at no charge to enrollees, and how to access language assistance services. At a minimum, these processes shall include the following:

(i) Processes to promote effective identification of LEP enrollee language assistance needs at points of contact, to ensure that LEP enrollees are informed at points of contact that interpretation services are available at no cost to the LEP enrollee, and to facilitate individual enrollee access to interpretation services at points of contact.

(ii) Processes for including the notice required by Section 1367.04(b)(1)(B)(v) with all vital documents, all enrollment materials and all correspondence, if any, from the plan confirming a new or renewed enrollment. If documents are distributed in an LEP enrollee's preferred written language the notice need not be included.

(iii) Processes for including statements, in English and in threshold languages, about the availability of free language assistance services and how to access them, in or with brochures, newsletters, outreach and marketing materials and other materials that are routinely disseminated to the plan's enrollees.

(D) Processes to ensure the plan's language assistance program conforms with the requirements of section 1300.68(b)(3) and (7) of these regulations, including standards to ensure that LEP enrollees receive information regarding their rights to file

a grievance and seek an independent medical review in threshold languages and through oral interpretation.

(i) All plans shall ensure that grievance forms and procedures in threshold languages are made readily available to enrollees and to contracting providers for distribution to enrollees upon request.

(ii) All plans shall inform contracting providers that informational notices explaining how enrollees may contact their plan, file a complaint with their plan, obtain assistance from the Department and seek an independent medical review are available in non-English languages through the Department's web site. The notice and translations can be obtained online at [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov) for downloading and printing. In addition, hard copies may be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814.

(E) Processes to ensure that contracting providers are informed regarding the plan's standards and mechanisms for providing language assistance services at no charge to enrollees, and to ensure that LEP language needs information collected by the plan is made available to contracting providers.

(F) Processes and standards for providing translation services, including, but not limited to:

(i) A list of the threshold languages identified by the plan;

(ii) A list of the types of standardized and enrollee-specific vital documents that must be translated and the applicable standards for making translated vital documents available to subscribers and enrollees. Plans need not translate subscriber contracts, evidences of coverage and other large disclosure forms and enrollee handbooks in their entirety, but may excerpt from large documents the disclosures specified at subsection (b)(7)(G) for translation in a format that permits cost-effective and timely production and distribution, so long as there is no loss of accuracy or meaning by doing so. A plan may demonstrate compliance regarding translation of the disclosures specified at subsection (b)(7)(G) if the plan provides a standardized matrix that lists the major categories of health care services covered under the plan's subscriber contracts, together with the corresponding co-payments and coinsurance, and exclusions and limitations, and disclosing any applicable deductibles and lifetime maximums, using the same sequence as the uniform matrix described at Section 1363(b)(1) of the Act.

(iii) A description of how the plan will provide or arrange for the provision of translation of vital documents at no charge to enrollees in accordance with the requirements of Section 1367.04 of the Act and this section. This subsection is not intended to prohibit or discourage a plan from providing translation of vital documents into a greater number of languages than the threshold languages;

(iv) A requirement that non-English translations of vital documents must meet the same standards required for English language versions of those documents; and

(v) A requirement that, with respect to vital documents that are not standardized, but which contain enrollee-specific information, a plan shall provide the English version together with the Department-approved written notice of the availability of interpretation and translation services and, if a translation is requested, the plan shall provide the requested translation in accordance with the requirements of Section 1367.04 of the Act and this section.

(G) Processes and standards for providing individual enrollee access to interpretation services at points of contact at no charge, including, but not limited to:

(i) A list of the non-English languages likely to be encountered among the plan's enrollees.

(ii) A requirement that the plan shall provide LEP enrollees with interpretation services for information contained in plan-produced documents.

(iii) A requirement that qualified interpretation services be offered to LEP enrollees, at no cost to the enrollee, at all points of contact, including when an enrollee is accompanied by a family member or friend that can provide interpretation services. The offer of a qualified interpreter, and the enrollee's refusal if interpretation services are declined, shall be documented in the medical record or plan file, as applicable.

(iv) When an enrollee needs interpretation services at a point of contact that occurs in a hospital, facility or provider office subject to federal or state law that requires the hospital, facility or provider office to provide interpretation services, the plan is not relieved of its obligation to comply with the requirements of Section 1367.04 of the Act or this section. Full service plans shall have reasonable processes in place to ensure that LEP enrollees can obtain the plan's assistance in arranging for the provision of timely interpretation services at all points of contact as defined at subsection (b)(4).

This subsection does not prohibit a plan from incorporating into its language assistance program a contracting hospital's language assistance program if: the hospital's language assistance program provides access to interpretation services consistent with the requirements of Section 1367.04 of the Act and this section; the plan monitors for deficiencies in delivery of interpretation services by the hospital; and the plan takes appropriate corrective action to address hospital deficiencies in delivery of interpretation services to the plan's enrollees. This subsection is not intended to limit or expand any existing state or federal law.

(v) A description of the arrangements the plan will make to provide or arrange for the provision of timely interpretation services at no charge to LEP enrollees at all points of contact where language assistance is needed. For purposes of this subsection "timely" means in a manner appropriate for the situation in which language assistance is needed. Interpretation services are not timely if delay results in the effective denial of the service, benefit, or right at issue. A plan's language assistance program shall specify quality assurance standards for timely delivery of language assistance services for emergency, urgent, and routine health care services, and shall include standards for coordinating interpretation services with appointment scheduling.

(vi) The range of interpretation services that will be provided to enrollees as appropriate for the particular point of contact. The range of services may include, but is not limited to:

(aa) Arranging for the availability of bilingual plan or provider staff who are trained and competent in the skill of interpreting;

(bb) Hiring staff interpreters who are trained and competent in the skill of interpreting;

(cc) Contracting with an outside interpreter service for trained and competent interpreters;

(dd) Arranging formally for the services of voluntary community interpreters who are trained and competent in the skill of interpreting; and

(ee) Contracting for telephone, videoconferencing or other telecommunications supported language interpretation services.

(vii) As used in this section, “trained and competent in the skill of interpreting,” “qualified interpretation services” and “qualified interpreter” means that the interpreter meets the plan’s proficiency standards established pursuant to subsection (c)(2)(H). (H) The plan’s policies and standards for ensuring the proficiency of the individuals providing translation and interpretation services. A plan may develop and apply appropriate criteria for ensuring the proficiency of translation and interpretation services or may adopt certification by an association acceptable to the Department at the time of certification. A plan’s language assistance proficiency standards shall require:

- (i) A documented and demonstrated proficiency in both English and the other language;
- (ii) A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems; and
- (iii) Education and training in interpreting ethics, conduct and confidentiality. The Department will accept plan standards for interpreter ethics, conduct, and confidentiality that adopt and apply, in full, the standards promulgated by the California Healthcare Interpreters Association or the National Council on Interpreting in Healthcare.

**28 CCR 1300.67.04(e)(2)**

(e) Implementation.

(2) By July 1, 2008, every plan shall file, in accordance with Section 1352 of the Act, an amendment to its quality assurance program providing its written language assistance program policies and procedures, together with information and documents sufficient to demonstrate compliance with the requirements and standards of Section 1367.04 of the Act and this section. The filing shall include the plan’s Section 1367.04(b)(1)(B)(v) notices. All materials filed with the Department that contain documents in non-English languages shall include the following minimum supporting documentation:

- (i) The English version of each non-English document.
- (ii) An attestation by the translator or, if applicable, by an authorized officer of the organization providing translator services, outlining the qualifications of the translator making the translation and affirming that the non-English translation is an accurate translation of the English version.

**28 CCR 1300.67.04(e)(4)**

(e) Implementation.

(4) Every contract between a health care provider and a plan, including a specialized plan, that is issued, amended, delivered or renewed on or after January 1, 2009, shall require compliance with the plan’s language assistance program standards developed pursuant to Section 1367.04 of the Act and this section.

(A) A plan shall retain financial responsibility for the implementation of the language assistance program required by Section 1367.04 of the Act and this section, except to the extent that delegated financial responsibility has been separately negotiated and specifically documented in written contracts. This subsection does not create an exception to Section 1367 of the Act and delegation

shall not constitute a waiver of the plan's obligation to provide language assistance services required by Section 1367.04 of the Act and this section.

(B) Delegation to contracting providers of any part of the plan's obligation to provide language assistance services required by Section 1367.04 of the Act and this section constitutes a material change to a provider contract subject to the requirements of Section 1375.7 of the Act.

**28 CCR 1300.68(b)(3) and (7)**

(b) The plan's grievance system shall include the following:

(3) The grievance system shall address the linguistic and cultural needs of its enrollee population as well as the needs of enrollees with disabilities. The system shall ensure all enrollees have access to and can fully participate in the grievance system by providing assistance for those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. Plans shall develop and file with the Department a policy describing how they ensure that their grievance system complies with this subsection within 90 days of the effective date of this regulation.

(7) Grievance forms and a description of the grievance procedure shall be readily available at each facility of the plan, on the plan's website, and from each contracting provider's office or facility. Grievance forms shall be provided promptly upon request.

**INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED**

**Staff responsible for the activities described above, for example:**

- Director of QM Program and/or executive with overall responsibility for the Plan's LA Program
- Manager and Staff of Member/Customer Services
- Director or Manager of Provider Networks or Provider Contracting, Delegated Programs
- Cultural and Linguistic Coordinator/ Language Assistance Program Coordinator

**DOCUMENTS TO BE REVIEWED**

- Plan's LA Program and LA policies & procedures
- Workflow / Process Map / Algorithm for accessing interpreter services by point of contact.
- If applicable, samples of translated documents such as applications, consent forms, standard and non-standard letters.
- Internal interpretation/translation staff proficiency assessment tool and sample of completed assessments.
- If the Plan has contracted with vendor, the vendor assessment tool and/or vendor proficiency requirements for LA services, interpretation and/or translation.

- Log(s) or report(s) of LA services provided by the Plan (directly or through vendor contracts)
- Log(s) or report(s) of LA services accessed through a provider’s office
- Sample of contracts/ contract amendments/ or Provider Manuals (if incorporated by reference in the provider contracts) between the Plan and Provider incorporating language regarding LA Program requirements
  
- IF THE PLAN DELEGATES LAP: Delegation pre-assessments, policies and procedures, delegation agreement, roles, responsibilities and Plan oversight;
  - Delegation audit tools, related documents
  - Delegate LAP policies and procedures, if applicable
  - Results of periodic audit of delegated activities, action plans.
  
- FOR SPECIALIZED PLANS:
  - Provider directory
  - Provider quarterly language capability updates regarding any changes
- Plan’s Web site (identifying all areas related to LA services, including but not limited to: notice of availability, translated vital documents, grievance forms and information, etc.)

**LA-003 - Key Element 1:**

**1. The Plan has established and implemented language assistance policies and procedures that address standards for providing language assistance services.**  
**28 CCR 1300.67.04(c)(2)(C)through (H)**

Assessment Questions	Yes	No	N/A
1.1 Has the Plan implemented processes for notifying the enrollee, and facilitating access to language services at no cost to the enrollee?			
1.2 Has the Plan defined all points of contact where the need for language assistance may be reasonably anticipated?			
1.3 Has the Plan defined how <b>translation</b> services are provided to enrollees? (Including how to request services, access services, etc.)			
1.4 Does the Plan have a process(es) to provide <b>interpretation</b> services to enrollees at all points of contact? (Including how to request services, access services, etc.)			

**LA-003 - Key Element 2:**

**2. The Plan demonstrates that it has processes and standards for informing enrollees of the availability of free LA services.**

**CA Health and Safety Code section 1367.04(b)(1)(B)(v); 28 CCR 1300.67.04(c)(2)(C); 28 CCR 1300.67.04(e)(4)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have processes to inform LEP enrollees of the availability of free LA services at all identified points of contact (medical and administrative)?			
2.2 Do the processes address both Plan and provider (such as Physicians, ancillary providers, pharmacies, facilities, etc.) points of contact?			
2.3 Does the Plan demonstrate that it includes the required notice (or translated versions of the documents) with all <b>vital documents, enrollment materials, and correspondence confirming new or renewed enrollment</b> , except when documents are sent in enrollee’s preferred language?			
2.4 Do the Plan’s brochures, newsletters, outreach and marketing materials, and other materials routinely disseminated to enrollees include statements – in English and in threshold languages, if applicable – regarding the availability of free language assistance services?			
2.5 Has the Plan made reasonable efforts to educate contracted medical providers, ancillary providers, and pharmacies about making interpretation services available for enrollees?			

**LA-003 - Key Element 3:**

**3. IF APPLICABLE: The Plan demonstrates that it has processes and standards in place for providing translation services.**

**CA Health and Safety Code section 1363(b)(1); CA Health and Safety Code section 1367.04(b)(1)(C); 28 CCR 1300.67.04(c)(2)(F); 28 CCR 1300.67.04(e)(2)**

Assessment Questions	Yes	No	N/A
3.1 Does the Plan demonstrate how it provides or arranges for translation of vital documents at no charge to enrollees?			
3.2 Does the Plan provide timely translation of vital documents to the enrollee?			
3.3 If the Plan is providing a standardized health plan benefits and coverage matrix, does it meet the requirements of CA Health & Safety Code Section 1363(b)(1)?			
3.4 Does the Plan include – with non-standardized enrollee specific documents – a written notice of the availability of free interpretation services?			

Assessment Questions	Yes	No	N/A
3.5 Does the Plan provide – upon the enrollee’s request – a written translation of a non-standardized enrollee-specific document into a threshold language within 21 days?			
3.6 For grievances that require expedited review, does the Plan provide notice of the availability of oral interpretation service?			
3.7 Does the Plan ensure that the translation is accurate?			
3.8 Does the Plan ensure that non-English translations of vital documents meet the same standards as the English versions?			

**LA-003 - Key Element 4:**

**4. The Plan demonstrates that it has processes and standards for ensuring the quality, accuracy, and timeliness of translation and interpretation services.  
28 CCR 1300.67.04(c)(2)(H)**

Assessment Questions	Yes	No	N/A
4.1 Has the Plan defined standards to ensure the quality and accuracy of written translations?			
4.2 Does the Plan ensure that a translated document meets the same standards required for the English version?			
4.3 Does the Plan define processes and standards for ensuring the proficiency of individuals or groups providing translation and interpretation services, including <b>internal Plan staff and contract or vendor staff</b> ?			
4.4 Do the Plan’s proficiency standards include <b>education and training</b> in interpreting ethics, conduct, and confidentiality?			
4.5 Does the Plan ‘test’ or ‘validate the quality’ of services provided by individuals or groups providing translation and interpretation services (documented and demonstrated proficiency in English and other language, fundamental knowledge in both languages of health care terminology and delivery system)?			

**LA-003 - Key Element 5:**

**5. The Plan demonstrates that it has processes and standards for providing interpretation services.  
28 CCR 1300.67.04(c)(2)(G)**

Assessment Questions	Yes	No	N/A
5.1 Does the Plan provide or arrange for interpretation services at no cost to the enrollee at all points of contact, including <b>medical/clinical and non-medical/administrative</b> points of contact? (Such as Physician’s office, ancillary services, pharmacies, facilities, hospitals, nurse advice lines,			

Assessment Questions	Yes	No	N/A
administrative offices, claims support contacts, etc.)			
5.2 Does the Plan specify quality assurance standards for timely delivery of interpretation services for <b><i>routine, urgent, and emergency</i></b> health care services?			
5.3 Does the Plan arrange or coordinate timely interpretation services for medical points of contact as well as administrative points of contact?			
5.4 Is the range of interpretation services appropriate for the particular point of contact? (Medical/clinical and non-medical/administrative)			
5.5 Does the Plan ensure that qualified interpretation services are offered to LEP enrollees, even when an enrollee is accompanied by a family member or friend that can provide interpretation services?			
5.6 If the offer is refused, is the information documented in the Plan file? (NOT REQUIRED FOR SPECIALIZED PLANS)			
5.7 Does the Plan provide evidence that interpretation services are available in languages other than threshold languages?			

**LA-003 - Key Element 6:**

**6. The Plan's grievance system addresses the cultural and linguistic needs of its enrollee population.**

**CA Health and Safety Code Section 1368; CA Health and Safety Code section 1367.04(b)(1)(B)(iii); 28 CCR 1300.68(b)(3) and (7); 28 CCR 1300.67.04(c)(2)(D)**

Assessment Questions	Yes	No	N/A
6.1 Does the Plan ensure that LEP enrollees receive information regarding their rights to <b><i>file a grievance or request an IMR</i></b> in threshold languages and through oral interpretation?			
6.2 Has the Plan translated and distributed grievance and IMR forms and procedures in threshold languages?			
6.3 Does the Plan ensure that these translated forms and procedures are readily available to <b><i>enrollees, contracting providers, contracting facilities, and on the Plan's Web site</i></b> ?			
6.4 Does the Plan offer interpretation services for LEP enrollees who file a grievance or seek an IMR?			
6.5 If an LEP enrollee requests a translation of a grievance or IMR non-standardized document with enrollee-specific information, does the Plan provide notice of availability of oral interpretation for cases requiring expedited review?			

## **End of Requirement LA-003: Language Assistance Services**

## Requirement LA-004: Staff Training

### STATUTORY/REGULATORY CITATIONS

#### 28 CCR 1300.67.04(c)(3)

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

(3) Staff training.

Every plan shall implement a system to provide adequate training regarding the plan's language assistance program to all plan staff who have routine contact with LEP enrollees. The training shall include instruction on:

- (A) Knowledge of the plan's policies and procedures for language assistance;
- (B) Working effectively with LEP enrollees;
- (C) Working effectively with interpreters in person and through video, telephone and other media, as may be applicable; and
- (D) Understanding the cultural diversity of the plan's enrollee population and sensitivity to cultural differences relevant to delivery of health care interpretation services.

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

**Staff responsible for the activities described above, for example:**

- Cultural and Linguistic Coordinator/ Language Assistance Program Coordinator
- Director of Human Resources
- Manager of Training
- Member / Customer Service Staff

### DOCUMENTS TO BE REVIEWED

- Language Assistance (LA) Program staff training curriculum
- LA Program training materials
- LA Program training schedule
- LA Training Program evaluation summaries
- Resumes of LA Program trainers

**LA-004 - Key Element 1:**

- 1. The Plan has established and implemented an LA Training Program for all staff who have routine contact with LEP enrollees.  
28 CCR 1300.67.04(c)(3)**

<b>Assessment Questions</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
1.1 Does the LA Training Program apply to all Plan staff that have routine contact with LEP enrollees, including employees (existing, new, transferred, etc.), contractors, sub-contractors, and/or affiliated staff?			
1.2 Is the Plan's training program comprehensive, including all key elements? (Working effectively with LEP enrollees, working with interpreters, cultural diversity, LA program elements.)			

**End of Requirement LA-004: Staff Training**

## **Requirement LA-005: Contracted Providers and the Language Assistance Program**

### **STATUTORY/REGULATORY CITATIONS**

#### **CA Health and Safety Code section 1367.04(f)**

(f) A contract between a health care service plan and a health care provider shall require compliance with the standards developed under this section. In furtherance of this section, the contract shall require providers to cooperate with the plan by providing any information necessary to assess compliance.

#### **28 CCR 1300.67.04(c)(1)(C)**

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

(1) Enrollee Assessment. Every health care service plan and specialized health care service plan shall assess its enrollee population to develop a demographic profile and to survey the linguistic needs of individual enrollees. In assessing its enrollee population each plan shall, at a minimum:

(C) Collect, summarize and document enrollee demographic profile data in a manner that enables the plan to maintain confidentiality of personal information and to disclose the information to the Department on request for regulatory purposes and to contracting providers on request for lawful purposes, including language assistance purposes and health care quality improvement purposes. This section is not intended to limit or expand existing law regarding confidentiality of medical records.

#### **28 CCR 1300.67.04(c)(2)(E)**

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

(2) Providing Language Assistance Services. Every plan shall develop language assistance program policies and procedures, which shall describe, at a minimum, the information outlined below.

(E) Processes to ensure that contracting providers are informed regarding the plan's standards and mechanisms for providing language assistance services at no charge

to enrollees, and to ensure that LEP language needs information collected by the plan is made available to contracting providers.

**28 CCR 1300.67.04(c)(2)(G)(iii) and (iv)**

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

(2) Providing Language Assistance Services. Every plan shall develop language assistance program policies and procedures, which shall describe, at a minimum, the information outlined below.

(G) Processes and standards for providing individual enrollee access to interpretation services at points of contact at no charge, including, but not limited to:

(iii) A requirement that qualified interpretation services be offered to LEP enrollees, at no cost to the enrollee, at all points of contact, including when an enrollee is accompanied by a family member or friend that can provide interpretation services. The offer of a qualified interpreter, and the enrollee's refusal if interpretation services are declined, shall be documented in the medical record or plan file, as applicable.

(iv) When an enrollee needs interpretation services at a point of contact that occurs in a hospital, facility or provider office subject to federal or state law that requires the hospital, facility or provider office to provide interpretation services, the plan is not relieved of its obligation to comply with the requirements of Section 1367.04 of the Act or this section. Full service plans shall have reasonable processes in place to ensure that LEP enrollees can obtain the plan's assistance in arranging for the provision of timely interpretation services at all points of contact as defined at subsection (b)(4). This subsection does not prohibit a plan from incorporating into its language assistance program a contracting hospital's language assistance program if: the hospital's language assistance program provides access to interpretation services consistent with the requirements of Section 1367.04 of the Act and this section; the plan monitors for deficiencies in delivery of interpretation services by the hospital; and the plan takes appropriate corrective action to address hospital deficiencies in delivery of interpretation services to the plan's enrollees. This subsection is not intended to limit or expand any existing state or federal law.

**28 CCR 1300.67.04(c)(2)(H)**

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

(2) Providing Language Assistance Services. Every plan shall develop language assistance program policies and procedures, which shall describe, at a minimum, the information outlined below.

(H) The plan's policies and standards for ensuring the proficiency of the individuals providing translation and interpretation services. A plan may develop and apply appropriate criteria for ensuring the proficiency of translation and interpretation services or may adopt certification by an association acceptable to the Department at the time of certification. A plan's language assistance proficiency standards shall require:

(i) A documented and demonstrated proficiency in both English and the other language;

(ii) A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems; and

(iii) Education and training in interpreting ethics, conduct and confidentiality. The Department will accept plan standards for interpreter ethics, conduct, and confidentiality that adopt and apply, in full, the standards promulgated by the California Healthcare Interpreters Association or the National Council on Interpreting in Healthcare.

**28 CCR 1300.67.04(c)(4)(A)**

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and standards for compliance monitoring.

(4) Compliance Monitoring.

(A) Every plan shall monitor its language assistance program, including delegated programs, and make modifications as necessary to ensure compliance with Section 1367.04 of the Act and this section.

**28 CCR 1300.67.04(d)(9)**

(d) In reviewing a plan's proposed language assistance program, the Department will evaluate the totality of the plan's language assistance program to determine whether the program as a whole provides meaningful access for LEP enrollees, and may consider relevant operational and demographic factors, including but not limited to:

(9) Specialized dental, vision, chiropractic, acupuncture and employee assistance program plans that demonstrate adequate availability and accessibility of qualified bilingual contracted providers and office staff to provide meaningful access to LEP enrollees, will be in compliance with the requirements of subsection (c)(2)(G)(iii) and (v). For the purposes of this subsection, specialized dental, vision, chiropractic, acupuncture and employee assistance program plans may demonstrate adequate availability and accessibility of competent and qualified bilingual providers and office staff if:

- A) The plan identifies within its provider directories those contracting providers who are themselves bilingual or who employ other bilingual providers and/or office staff, based on language capability disclosure forms signed by the bilingual providers and/or office staff, attesting to their fluency in languages other than English;
- B) The plan requires all contracting providers to provide quarterly updates regarding any changes in the language capabilities of currently employed providers and/or office staff by submitting new language capability disclosure forms, and the plan updates its provider directories accordingly, and consistent with Section 1367.26 of the Act; and
- C) The plan's quality assurance audits of contracting providers confirm and document the accuracy of provider language capability disclosure forms and attestations.

**28 CCR 1300.67.04(e)(4)(A) and (B)**

(e) Implementation.

(4) Every contract between a health care provider and a plan, including a specialized plan, that is issued, amended, delivered or renewed on or after January 1, 2009, shall require compliance with the plan's language assistance program standards developed pursuant to Section 1367.04 of the Act and this section.

(A) A plan shall retain financial responsibility for the implementation of the language assistance program required by Section 1367.04 of the Act and this section, except to the extent that delegated financial responsibility has been separately negotiated and specifically documented in written contracts. This subsection does not create an exception to Section 1367 of the Act and delegation shall not constitute a waiver of the plan's obligation to provide language assistance services required by Section 1367.04 of the Act and this section.

(B) Delegation to contracting providers of any part of the plan's obligation to provide language assistance services required by Section 1367.04 of the Act and this section constitutes a material change to a provider contract subject to the requirements of Section 1375.7 of the Act.

**28 CCR 1300.70(a)(1)**

(a) Intent and Regulatory Purpose.

(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

**28 CCR 1300.70(b)(2)(G)**

(b) Quality Assurance Program Structure and Requirements.

(2) Program Requirements.

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees. If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

- (1) Inform each provider of the plan's QA program, of the scope of that provider's QA responsibilities, and how it will be monitored by the plan.
- (2) Ascertain that each provider to which QA responsibilities have been delegated has an in-place mechanism to fulfill its responsibilities, including administrative capacity, technical expertise, and budgetary resources.
- (3) Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities.
- (4) Require that standards for evaluating that enrollees receive health care consistent with professionally recognized standards of practice are included in the provider's QA program, and be assured of the entity's continued adherence to these standards.
- (5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.
- (6) Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.

**28 CCR 1300.70(c)**

(c) In addition to the internal quality of care review system, a plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the Department.

**INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED**

**Staff responsible for the activities described above, for example:**

- Director of Provider Relations
- Medical Director
- Manager, Provider Contracting

**DOCUMENTS TO BE REVIEWED**

- Policies and Procedures that describe provider compliance with LAP standards.
- Standards and/or criteria for determining bilingual provider and office staff proficiency (SPECIALIZED PLANS ONLY)
- Provider Contracts, including contract templates or amendments to provider contracts that reference compliance with the Plan's LAP.
- Provider Manuals
- Sample Provider Newsletters
- Provider section of the Plan's Web site
- Provider Directory

**LA-005 - Key Element 1:**

**1. The Plan has amended provider contracts to require providers to comply with the LAP requirements and agreement to provide information necessary to assess compliance.**

**CA Health and Safety Code section 1367.04(f); 28 CCR 1300.67.04(c)(2)(G)(iii); 28 CCR 1300.67.04(c)(4)(A); 28 CCR 1300.67.04(e)(4)(A)**

Assessment Questions	Yes	No	N/A
1.1 Do Plan contracts with providers or an executed amendment to the provider contract require the provider to comply with the Plan's LA Program?			
1.2 Do the Plan's contracts with providers require providers to provide any information necessary to assess compliance?			
1.3 Do the Plan's contracts with providers require providers to document declinations of interpreter services in the medical record or patient file? (NOT REQUIRED FOR SPECIALIZED PLANS)			

**LA-005 - Key Element 2:**

**2. The Plan shall inform all contracted providers of its Language Assistance Program.**

**28 CCR 1300.67.04(c)(1)(C); 28 CCR 1300.67.04(c)(2)(E)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan disclose enrollee demographic profile data (including identification of the Plan's threshold languages) and language preference data gathered to contracting providers (including doctors' offices, hospitals, labs, radiology centers, physical therapy offices, and pharmacy services) upon request?			
2.2 Has the Plan established and implemented policies and procedures that ensure <b>contracted providers</b> (such as doctors' offices, hospitals, labs, radiology centers, physical therapy offices, and pharmacy services) <b>are informed</b> of the Plan's standards and methods for providing LA services at no charge to enrollees?			

**LA-005 - Key Element 3:**

**3. The Plan ensures that contracted bilingual providers and/or provider office staff are proficient to provide interpretation services.**

**CA Health and Safety Code section 1367.04(f), 28 CCR 1300.67.04(c)(2)(H), 28 CCR 1300.67.04(d)(9)**

<b>Assessment Questions</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
3.1 If the provider offers bilingual staff interpreter services, does the Plan's LA Program address monitoring of provider office language capabilities and proficiency?			
3.2 Do the Plan's language proficiency standards include: a) A documented and demonstrated proficiency in both English and the other language; b) A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems; and c) Education and training in interpreting ethics, conduct, and confidentiality?			
3.3 If no to 3.2, has the Plan adopted and applies, in full, the standards promulgated by the California Healthcare Interpreters Association or the National Council on Interpreting in Healthcare?			
3.4 Does the Plan provide enrollees with Provider Directories – reflecting the provider office language capabilities – upon request (in written form, via the Plan's Website, etc.)?			
<b>NOTE: FOR SPECIALIZED PLANS:</b> Specialized plans may choose to comply with <b>28 CCR 1300.67.04(d)(9) in place of complying with 28 CCR 1300.67.04(c)(2)(G)(iii) and (v).</b> Checking NO to these assessment questions <b>do not</b> automatically indicate the Plan is out of compliance.			
3.5 Does the Plan's provider directory identify those contracting providers who are bilingual or who employ other bilingual providers and/or office staff?			
3.6 Does the Plan require that bilingual providers and/or office staff complete and sign language capability disclosure forms attesting to their fluency in languages other than English?			
3.7 Does the Plan require all contracting providers to provide quarterly updates when there are any changes in the language capabilities of currently employed providers and/or staff by submitting new language capability disclosure forms?			
3.8 Do the Plan's quality assurance audits of contracting providers confirm and document the accuracy of provider language capability disclosure forms and attestations?			

**LA-005 - Key Element 4:**

**4. The Plan has established and implemented a delegation agreement and on-going oversight and monitoring of Language Assistance services delegated to contracted providers, hospitals, and/or facilities.**

**28 CCR 1300.67.04(c)(2)(G)(iv); 28 CCR 1300.67.04(c)(4)(A); 28 CCR 1300.67.04(e)(4); 28 CCR 1300.70(a)(1); 28 CCR 1300.70(b)(2)(G); 28 CCR 1300.70(c)**

<b>Assessment Questions</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
4.1 Does the Plan delegate the provision of any LA services (or incorporate a contracting hospital or provider group's LA Program)? <i><b>If 'No,' stop here; if 'Yes,' continue.</b></i>			
4.2 Does the Plan perform periodic oversight e.g., regular reports, periodic site visits of the delegated LAP function or program?			
4.3 Do minutes of appropriate committee meetings indicate regular Plan review of delegate reports and activities?			
4.4 Does the Plan identify and report on deficiencies of the delegated LA Program?			
4.5 Does the Plan implement corrective action and conduct follow-up reviews to address any deficiencies?			

**End of Requirement LA-005: Contracts with Providers**

## Requirement LA-006: Compliance Monitoring

### STATUTORY/REGULATORY CITATIONS

#### **28 CCR 1300.67.04(c)(4)(A)**

(c) Language Assistance Program Requirements.

Every plan shall develop and implement a language assistance program, which shall comply with the requirements and standards established by Section 1367.04 of the Act and this section. The language assistance program shall be documented in written policies and procedures, and shall address, at a minimum, the following four elements: standards for enrollee assessment; standards for providing language assistance services; standards for staff training; and **standards for compliance monitoring. (Emphasis added.)**

(4) Compliance Monitoring.

(A) Every plan shall monitor its language assistance program, including delegated programs, and make modifications as necessary to ensure compliance with Section 1367.04 of the Act and this section.

#### **28 CCR 1300.67.04(f)**

The Department will periodically review plan compliance with the standards and requirements of section 1367.04 of the Act and this section by methods that may include, but are not limited to, the medical survey process, reviews of consumer grievances and complaints to the Department's HMO Help Center, and provider complaints submitted to the Department's provider complaint line. The Department may also periodically request that plans submit information and data regarding enrollee language needs and demographic profile.

#### **28 CCR 1300.70(c)**

(c) In addition to the internal quality of care review system, a plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the Department.

#### **28 CCR 1300.70(b)(1) and (2)(B), (F) and (G)**

(b) Quality Assurance Program Structure and Requirements.

(2) Program Requirements.

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

(B) Written documents shall delineate QA authority, function and responsibility, and provide evidence that the plan has established quality assurance activities and that the plan's governing body has approved the QA Program. To the extent that a plan's QA responsibilities are delegated within the plan or to a contracting provider, the plan documents shall provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.

(F) There must be administrative and clinical staff support with sufficient knowledge and experience to assist in carrying out their assigned QA activities for the plan and delegated entities.

(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.

**INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED**

**Staff responsible for the activities described above, for example:**

- Language Assistance Program Coordinator/Compliance Officer or equivalent
- QA Director or equivalent
- Grievances and Appeals Coordinator/ Customer Service Director
- Provider Relations staff
- Staff responsible for developing and analyzing reports of the Language Assistance Program
- Accounting Manager (Usage Reports)

**DOCUMENTS TO BE REVIEWED**

- Exhibit J e-filing/ amendment to QA Program related to LAP and any updates
- QA Work Plans related to LA Program or services  
Monitoring and Evaluation reports noted in the LAP QA Work Plan Activities, e.g., LAP grievances, PQI, provider complaints, language line usage reports
- Plan’s evaluation of LAP

**LA-006 - Key Element 1:**

**1. The Plan has defined policies and has implemented an active and ongoing program to continuously monitor the compliance of its LA Program.  
28 CCR 1300.67.04(c); 28 CCR 1300.70(b)(1) and (2)(B), (F), and (G)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have policies and procedures (or other documentation) that defines how the Plan monitors its Language Assistance Program?			
1.2 Does the Plan have a designated person and/or department responsible for LAP monitoring?			
1.3 Does the Plan’s monitoring program include internal (and external, if appropriate) LAP monitoring?			
1.4 Does the Plan monitor, evaluate, and take action as appropriate, measuring the four LA Program components: enrollee assessment, provision of language assistance services, staff training, and compliance?			
1.5 Does the Plan have a mechanism to ensure that network			

<b>Assessment Questions</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
providers comply with LA requirements?			
1.6 Are reports from LAP compliance monitoring submitted and reviewed through the Plan's QA reporting channels (and/or committee structure)?			
1.7 Does the Plan re-measure its performance to determine if the corrective actions have resulted in improved performance or the ability to meet compliance goals?			

**End of Requirement LA-006: Compliance Monitoring Requirement**

## DHCS REQUIREMENTS FOR GMC PROGRAMS

### Requirement LA-007: Linguistic Services

#### CONTRACT CITATIONS

#### Medi-Cal Dental GMC Program Exhibit A, Attachment 11, Provision H

##### (H) Linguistic Services

1. Contractor shall ensure equal access to dental care services for limited English proficient Members through provision of high quality interpreter and linguistic services.

2. Contractor shall comply with 42 CFR 438.10(c) and ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour interpreter services at all key points of contact, as defined in Subprovision 3 of this Provision, either through interpreters or telephone language services.

3. Contractor shall provide, at minimum, the following linguistic services at no cost to Medi-Cal Members:

a. Interpreters, signers, or bilingual providers and provider staff at all key points of contact. These services shall be provided to all Members and not limited to those that speak the threshold or concentration standards languages.

b. Fully translated written informing materials, including but not limited to the Member services guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by DHCS within the Contractor's service area, and by the Contractor in its group needs assessment.

c. Referrals to culturally and linguistically appropriate community service programs.

d. Telecommunications Device for the Deaf (TDD)

TDDs are electronic devices for text communication via a telephone line used when one or more of the parties have hearing or speech difficulties. TDDs are also known as TTY, which are telephone typewriters or teletypewriters, or teletypes in general.

e. Telecommunications Relay Service (711)

The 711-telephone number is the Telecommunications Information Relay Service that connects a hearing impaired person with a specially trained operator who acts as an intermediary, relaying conversations between hearing persons and persons using a TDD/TTY device.

4. Contractor shall provide translated materials to the following population groups within its service area as determined by DHCS:

a. A population group of mandatory Medi-Cal beneficiaries residing in the service area who indicate their primary language as other than English and that meet a numeric threshold of 3,000.

b. A population group of mandatory Medi-Cal beneficiaries residing in the service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.

5. Key points of contact include:

- a. Dental care settings: telephone, advice and urgent care transactions, and encounters with dental care providers including pharmacists.
- b. Non-medical care setting: Member services, orientations, and appointment scheduling.

**INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED**

**Staff responsible for the activities described above, for example:**

- Language Assistance Program Coordinator/Compliance Officer or equivalent
- QA Director or equivalent
- Grievances and Appeals Coordinator/ Customer Service Director
- Provider Relations staff
- Staff responsible for developing and analyzing reports of the Language Assistance Program
- Accounting Manager (Usage Reports)

**DOCUMENTS TO BE REVIEWED**

- Exhibit J e-filing/ amendment to QA Program related to LAP and any updates.
- Policies and procedures/description of methodology used to identify population group of mandatory Medi-Cal beneficiaries residing in the service area who indicate their primary language as other than English and that meet a numeric threshold of 3,000.
- QA Work Plans related to LA Program or services.
- Monitoring and Evaluation reports noted in the LAP QA Work Plan Activities, e.g., LAP grievances, PQI, provider complaints, language line usage reports.
- Plan’s evaluation of LAP, inclusive of the GMC contract obligations.

**LA-007 - Key Element 1:**

**1. Linguistic Services: The Plan provides interpreter and linguistic services for monolingual and limited English proficient Medi-Cal Beneficiaries. Medi-Cal Dental GMC Program Exhibit A, Attachment 11, Provision H**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan provide interpreter and linguistic services for limited English proficient Members?			
1.2 Does the Plan ensure that all monolingual, non-English-speaking, or limited English proficient (LEP) Medi-Cal beneficiaries receive 24-hour interpreter services at all key			

<b>Assessment Questions</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
<p>points of contacts? Key points of contact in a Dental care setting are defined as telephone, advice and urgent care transactions, and encounters with dental care providers including pharmacists. Key points of contact in a non-medical care setting are defined as Member Services, orientations, and appointment scheduling.</p>			
<p>1.3 Does the Plan provide interpreters, signers, or bilingual providers and provider staff at all key points of contact at no cost to Members?</p>			
<p>1.4 Does the Plan provide Telecommunications Device for the Deaf (TDD) services at no cost to Members?</p>			
<p>1.5 Does the Plan provide Telecommunications Relay Service (711) at no cost to Members?</p>			
<p>1.6 Does the Plan have an established methodology/process for identifying population groups of mandatory Medi-Cal beneficiaries residing in the service area who indicate their primary language as other than English who meet a numeric threshold of 3,000, or who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes?</p>			
<p>1.7 Does the Plan provide translated materials to the following population groups within its service area as determined by DHCS? a) A population group of mandatory Medi-Cal beneficiaries residing in the service area who indicate their primary language as other than English and that meet a numeric threshold of 3,000. b) A population group of mandatory Medi-Cal beneficiaries residing in the service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.</p>			
<p>1.8 Does the Plan provide fully translated materials including member service guides, enrollee information, welcome packets, marketing information, form letters, including notice of action letters, and grievance acknowledgement and resolution letters, to all monolingual or LEP members that speak the threshold or concentrated standard languages?</p>			

**End of Requirement LA-007: Linguistic Services**