

## BEHAVIORAL HEALTH ISSUE BRIEF SERIES

# Cultural Competence in Medicaid Managed Care Purchasing: General and Behavioral Health Services for Persons With Mental and Addiction-Related Illnesses and Disorders

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### Introduction

This Issue Brief explores cultural competence. Employing the data base from the large-scale Medicaid contract analysis conducted annually by the Center for Health Services Research and Policy (CHSRP),<sup>1</sup> we examine the approaches that state agencies take in implementing the concept of cultural competence in the design and implementation of their managed care systems.

For purposes of this Issue Brief we examined both general service contracts and purchasing documents specifically related to behavioral health. While the focus of this Issue Brief is individuals with mental illness and addiction disorders, we have examined both sets of data for three reasons. First, many Medicaid general services agreements (even those in states that maintain separate behavioral health contracts) cover at least a basic level of care related to mental illness and addiction disorders, with separate behavioral health contracts reserved for persons with severe conditions. As a result, even general service companies may furnish a significant level of mental illness and addiction-related services. Second, the cultural competence of contractors that furnish only physical health services is extremely important to persons with mental illness and addiction disorders, since they obtain their

physical health services through these providers (behavioral health carve-out contracts are confined to coverage of behavioral health services).

Third, as is apparent from the excerpts presented in this Issue Brief, cultural competency provisions are not drafted on a diagnostic-specific basis. These provisions are meant to cover the entire enrollee population, regardless of their health status. As a result, with the exception of the behavioral health-specific contracts (whose cultural competency provisions are presented throughout the document), there simply are no examples of cultural competency clauses that have been drafted only for persons with mental illness and addiction disorders.

This Issue Brief begins with a Background and Overview that discusses the general issue of patient/professional interaction as an essential dimension of health care quality and access and reviews research on the specific role of cultural competence in promoting quality health care relationships and health outcomes. It then presents findings from CHSRP's contract data base regarding the extent to which state purchasing documents currently address key aspects of cultural competence. We conclude with a discussion of the implications of the findings for health care access and quality.

In preparing this Issue Brief we have made extensive use of an excellent literature review on cultural competence that has been prepared for the Substance Abuse and Mental Health Services Administration by Dr. Barbara Bazron and Leslie Scallet of The Lewin Group.<sup>2</sup>

## **Background and Overview**

### **In General**

For decades, health experts have understood that the quality of medical care is determined not only by technical clinical competency but also by the quality of the interaction between health professionals and patients. This interaction appears to influence both the degree to which a patient is able to benefit from health care as well as the extent to which a health professional maintains a high-level personal commitment toward an individual patient. In managed care, which is characterized by the development and application of broadly conceived health care practice and management norms,<sup>3</sup> the ability of physicians and other health professionals to connect with their patients on an individual

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<sup>2</sup> Barbara Bazron and Leslie Scallet, "The Impact of Culturally and Linguistically Appropriate Services on Access to Care In a Managed Behavioral Health Care Environment" (The Lewin Group, 1998 (Working Draft)).

<sup>3</sup> *See, e.g.*, Milliman and Robertson, *Health Care Guidelines* (1995); General Accounting Office, *Managed Care Plans Customize Guidelines to Meet Local Interests* (GAO-HEHS-96-95, Washington, D.C., May, 1996).

basis takes on added importance, because of concerns on the part of consumers and providers alike regarding the potential of corporate norms to effectively de-personalize health care and treatment decision-making. Thus, in a health system in which corporate performance standards drive organization, financing, treatment decision-making, delivery, and quality measurement, strong professional-patient relationships represent an important countervailing force.

The importance to access and quality of health professional-patient interactions has been well understood for many years. In a seminal study of health care quality, Dr. Raymond Duff and Dr. August Hollingshead conducted a unique examination of the interpersonal relationships between physicians and patients at a major teaching hospital.<sup>4</sup> Duff and Hollingshead concluded that the highest level of relationship, which they termed “committed sponsorship”, was characterized by a higher degree of interest on the physician’s part in an individual patient. This level of interest extended beyond clinical concern over the patient’s disease and reached a measurable concern for the patient’s overall well-being in a health care environment. Researchers contrasted the experience of patients with “committed sponsors” to those who were “committee sponsored”, a term meant to indicate care by house staff with almost no individualized interaction. Committee sponsored patients were significantly poorer and sicker. Duff and Hollingshead found that:

No one on the hospital staff, either doctors or nurses, knew much about the patients as people, their personal situations, mental status, or feelings about their illness. By contrast, both nurses and doctors had consistent and accurate knowledge of the patient’s social status. The failure to know the patients as people led to high levels of misdiagnosis, *particularly failure to recognize alcoholism, mental illness and pain*, in all classes of patients. Few dying patients were informed of their prognosis, and all who were told were white men of high status.<sup>5</sup> (Emphasis added.)

Thirty years later the concept of a committed sponsor still can be thought of as the overarching goal of any health system. Reaching that goal requires that services be furnished in a culturally competent fashion, as the term has come to be used.

### Elements of Cultural Competency

Bazron and Scallet define culturally competent services as those that are “responsive to the unique cultural needs of bicultural/bilingual and culturally distinct populations.” They note that such services may “facilitate access and increase compliance with care by overcoming many of the historical barriers that have prevented underserved and minority populations from seeking or remaining in behavioral health programs.”<sup>6</sup> In summarizing the

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<sup>4</sup> Raymond S. Duff and August B. Hollingshead, *Sickness and Society* (1968).

<sup>5</sup> Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, Old Westbury, N.Y., 1997; 1998 and 1999 Supplements), at 839.

<sup>6</sup> *The Impact of Culturally and Linguistically Appropriate Services*, *supra* note 2, at 3.

literature on cultural competence, Bazron and Scallet identify eight distinct dimensions of the issue:

Location of health care providers in ethnically identifiable neighborhoods;

Literature that is accessible and understandable by patients regardless of language or ethnicity;

Ethnic diversity among providers;

Proficiency among health care providers in the languages spoken by patients;

Provider participation in cultural competency training;

Coverage of alternative medicine interventions;

The use of medical necessity criteria that incorporate consideration of cultural beliefs and needs that may affect the type of intervention used; and

Access and utilization performance measures that are specifically geared to measuring access by ethnically and identifiable populations.

In considering the issue of cultural competency, we have incorporated gender and sexual orientation as an additional measure. We also have added four measures designed to ensure that the review takes into account the nature of managed care. The four managed care-specific measures, which, as the findings below indicate, have also been identified by many states, are as follows:

*Treatment of new enrollees.* Critical to effective participation in managed care is the period of time immediately following enrollment, when many members select their primary care providers.<sup>7</sup> We were thus interested in the number of states that address cultural competence from the time of enrollment, as individuals make the transition into their plans.

*Culturally competent administration.* Also important in managed care is a trained and culturally competent staff to oversee all phases of managed care administration. In light of the need on the part of many enrollees to interact either directly or indirectly with managed care administrative staff (e.g., obtaining information and assistance, having a request for care reviewed by utilization management personnel, identifying or changing providers, or

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<sup>7</sup> In most states, primary care physician selection occurs following enrollment into a plan. See Kathleen Maloy, Julie Darnell, Karen Silver, and Sara Rosenbaum, *Results of a Ten-State Study of Medicaid Managed Care Enrollment* (The George Washington University Medical Center, School of Public Health and Health Services, Center for Health Policy Research, Washington, D.C., 1998) [Prepared for the Henry J. Kaiser Family Foundation, the David and Lucile Packard Foundation Center on the Future of Children, the Center for Health Care Strategies, and the Health Resources and Services Administration].

filing grievances and appeals), the same considerations related to ethnic diversity of staff, language proficiency, participation in cultural competency training, and accessible locations might be expected of administrative staff, as well.

*Interpreter services.* The availability of interpreter services at all phases of health plan operations, ranging from clinical visits to administrative encounters, is important. We add this measure because Medicaid managed care programs generally limit patient choice to fixed network providers (and they do not offer a point-of-service option to obtain non-network care on a covered basis, unless expressly authorized by the plan). In a system that imposes significant restrictions on patient selection of community providers, there may be an even greater likelihood that members will lack providers who are fluent in their language. As a result, access to translation services is important.

*Performance measurement and payment.* Finally, we were interested in the extent to which agencies address cultural competence in their performance measurement and payment structures. While the medical assistance costs incurred by beneficiaries are reflected in the premiums, certain costs associated with promoting cultural competency, such as translation of materials, hiring interpreters, and training providers and utilization review staff, reflect additional administrative costs that may be incurred both by the companies and their providers. As a result, a state might instruct its plans to include in their payments to providers additional sums to cover certain cultural competency activities. Additionally, since cultural competency considerations are extremely important to various sub-groups of members, we were interested in how states measure performance under the various cultural competence provisions they include in their agreements.

## Cultural Competency Requirements Under Federal and State Law

### *a. The Medicaid Statute*

The Balanced Budget Act of 1997 (the Act) amended the Medicaid statute to establish comprehensive standards applicable to most Medicaid managed care plans. While the Act does not contain express provisions regarding cultural competency, it does require that states and managed care entities provide informational and instructional materials to both enrollees and potential enrollees “in a manner and form which may be easily understood.” Furthermore, states must develop and maintain quality assessment and improvement strategies that include standards for access to care “so that covered services are available within reasonable time frames and in a manner that ensures continuity of care and adequate primary care and specialized services capacity.”<sup>8</sup> In addition, states covered by the amendments must have “procedures for monitoring and evaluating the quality and appropriateness of care and services that reflect the full spectrum of populations enrolled

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<sup>8</sup> Section 1932(a)(5)(A) of the Social Security Act; 42 U.S.C. §1396v(a)(5)(A).

under the contract.”<sup>9</sup>

*b. HCFA Regulations*

Proposed regulations issued by the Health Care Financing Administration (HCFA) on September 29, 1998<sup>10</sup> would significantly revise and amend the existing Medicaid managed care regulatory framework in a number of ways relevant to cultural competency.

Language: First, the proposed rules would establish language requirements related to the provision of information to enrollees and potential enrollees. The proposed rule would require states to “establish a methodology for determining the prevalent language or languages in a geographic area.”<sup>11</sup> It would also require states to make information available “in the languages that predominate throughout the state and require each [managed care entity] to make its information available in the languages that predominate in its particular service area.”<sup>12</sup> In addition, the proposed rule would require states to “make translation services available and require each [managed care entity] to make translation services available to meet the needs of all enrollees and potential enrollees.”<sup>13</sup>

The proposed rule does not define the terms “prevalent” or “predominate”, nor do the proposed standards explain whether the phrase “to meet the needs of all” enrollees and potential enrollees covers both medical and administrative services. The Preamble to the proposed rule states as follows:

We are proposing to require that state agencies establish a methodology for determining the prevalent languages spoken by populations in a geographic area and include provisions in their [managed care entity] contracts to ensure that materials are available in those specified languages. For example, state agencies could develop methodologies for estimating the composition of the Medicaid population by cultural groups that speak languages other than English, that is cultural groups that represent at least 5 percent of the Medicaid population. Enrollees and potential enrollees must be informed about how to obtain this information. Specific methodologies, such as those based on a consideration of geographic composition, population density, or enrolled population are not imposed by this regulation, as the most appropriate approach to fulfilling this requirement may vary from state to state. However, we are proposing that the state agency, enrollment broker and [managed care entity] be required to have translation services available for each enrollee and potential enrollee who has limited English proficiency and that potential enrollees be informed about how to obtain these

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<sup>9</sup> Section 1932(c)(A)(i) of the Social Security Act; 42 U.S.C. §1396v(c)(A)(i).

<sup>10</sup> For an analysis of these proposed regulations, see Sara Rosenbaum and Julie Darnell, *An Analysis of Proposed Medicaid Managed Care Regulations Issued by the Health Care Financing Administration* (Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., October, 1998).

<sup>11</sup> Proposed 42 C.F.R. §438.10(b)(1).

<sup>12</sup> Proposed 42 C.F.R. §438.10(b)(2).

<sup>13</sup> Proposed 42 C.F.R. §438.10(b)(3).

services.<sup>14</sup>

Access: The proposed rules require that in the provision of services, states must ensure that managed care organizations (MCOs) provide care “in a culturally competent manner to all enrollees, including at least the language requirements of §438.10.”<sup>15</sup> While the proposed rule does not define cultural competency, it refers back to the language rule. This proposed rule thereby appears to clarify that care itself needs to be furnished in a language appropriate fashion, at least with respect to prevalent/predominant languages, and that interpreter services be made available for persons of all languages.

In the accompanying Preamble to the proposed rule, HCFA states:

This requirement is proposed here because of our recognition that more than half of all Medicaid program beneficiaries are members of a racial or ethnic minority group. We know that managed care organizations and advocates have made great strides in developing culturally competent approaches and would expect a state agency to work with them and others in setting its standards. Accordingly, state agencies should ensure that managed care organizations identify significant sub-populations within their enrolled population that may experience special barriers to accessing health services, such as the homeless or enrollees who are part of a culture with norms and practices that may affect their interaction with the mainstream health care system. State agencies should ensure that MCOs make continued efforts to improve accessibility of *both clinical and member services* for these specific groups.

Cultural competency requires awareness of the culture of the population being serviced. Therefore, in order to ensure services are provided in a culturally competent manner, state agencies should require MCOs to give racial and ethnic minority concerns full attention, beginning with their first contact with the enrollee, continuing throughout the care process, and *extending afterward when care is evaluated*. Translation services must be made available when language barriers exist \* \* \*. Furthermore the MCOs network should include an adequate number of providers, commensurate with the population enrolled, who are aware of the values, beliefs, customs and parenting styles of the community. This awareness includes but is not limited to a provider being cognizant, among other things, of the importance of non-verbal communication, the recognition of specific dietary customs unique to certain populations, and the existence of folk medicines or healing rituals that may be used by enrollees. In addition, cultural competence requires network providers to have knowledge of medical risks enhanced in, or peculiar to, the racial, ethnic and socioeconomic factors of the population being served. Accordingly, MCOs should have accurate epidemiological data from which to form appropriate education, screening, and treatment programs.<sup>16</sup> [Emphasis

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<sup>14</sup> 63 Fed. Reg. 52022, 52029 (September 29<sup>th</sup>, 1998).

<sup>15</sup> Proposed 42 C.F.R. §438.306(e)(4).

<sup>16</sup> 63 Fed. Reg. 52022, 52045 (September 29<sup>th</sup>, 1998).

added.]

The scope of the Preamble suggests that HCFA in fact recognizes as relevant to cultural competency all of the factors identified in cultural competency literature as well as the factors, noted in this Issue Brief, that are unique to managed care. However, the proposed rules do not require specific payment mechanisms to address the cost of cultural competency adaptation.

*c. Title VI of the 1964 Civil Rights Act*

Title VI of the 1964 Civil Rights Act prohibits entities that receive federal financial assistance from engaging in practices that have the effect of discriminating on the basis of race or national origin.<sup>17</sup> Managed care organizations that participate in Medicaid are considered federal assistance recipients. Barriers created by language or issues of national origin have been deemed unlawful under the Act;<sup>18</sup> as a result, entities have a duty to ensure that such barriers are eliminated.

*d. State Human Rights Laws*

Virtually all states have enacted human rights legislation that may reach the conduct of both private individuals as well as entities that receive state or local funds, participate in state or local programs, or are regulated under state or local law. Many of these state statutes (which in the absence of an exemption applicable to managed care entities would apply to Medicaid managed care) prohibit certain forms of discriminatory practices that impair access by specific, identified subclasses of individuals such individuals from racial and ethnic minority groups, those from different cultures or with unique religious beliefs, and gay or lesbian individuals. Where such laws exist, contractors may have an affirmative obligation to ensure that their services are accessible and thus “culturally competent.”

## **Relevant Findings from the Contract Data Base**

### **In General**

Table 1 presents an overview of findings from CHSRP’s managed care contract data base. It identifies those states whose contract provisions could reasonably be interpreted as requiring certain types of performance on the part of their managed care contractors. A number of states include language related to one or more aspects of cultural competency that could be interpreted as indicating a preference or desire for certain culturally competent activities on the part of an MCO. However, the specification may be expressed

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<sup>17</sup> 42 U.S.C. §2000 et seq. and its implementing regulations. For a review of civil rights issues in managed care, see S. Rosenbaum et al., “Civil Rights in a Changing Health Care System,” *Health Affairs* 16:1 (January/February, 1997), pp. 90-105.

<sup>18</sup> *Lau v Nichols*, 414 U.S. 563 (1974).

in general terms without clear performance measures or, in a few cases, in expressly optional terms that underscore that compliance is optional.

An example of a provision that is expressly optional is the following excerpt from Hawaii's purchasing specifications in both its general and behavioral health service agreements. The general agreement specifies that:

The purpose of cultural/linguistic services is to facilitate the provision of appropriate and necessary health services to multiple ethnic groups in the recipient population. The provision of cultural/linguistic services *has been made optional*. However, the plans will remain responsible for identifying cultural/linguistic needs and shall assist the recipient in obtaining needed services. If the plan is unable to provide such services, the plan shall refer the recipients to DHS who will contract with providers of cultural/linguistic services.<sup>19</sup>

Similarly, Hawaii's behavioral health agreement specifies that:

The plan shall be responsible for identifying cultural/linguistic needs (e.g., interpretation services) and shall assist the recipient in obtaining needed services. If the plan is unable to provide the services, the plan shall refer the recipient to [the state agency] who will secure the appropriate services for the recipient.<sup>20</sup>

In all, of the forty-five purchasing documents in the 1998 data base, twenty-nine contain a general cultural competency provision,<sup>21</sup> while ten actually define the term "cultural competence."<sup>22</sup> Table 2 shows that as a group, the behavioral contracts are somewhat more likely than the general agreements to contain a broadly worded cultural competency provision. Examples can be found in the following excerpts from the contracts:

(a) "Services shall be culturally appropriate."<sup>23</sup>

(b) "Services shall be administered with recognition and sensitivity to every individual regardless of cultural heritage."<sup>24</sup>

(c) "Residents of the State of Iowa bring a diversity of cultural, racial, and ethnic backgrounds. Bidders must discuss how they will ensure access to treatment services for all cultural, ethnic and gender groups, to include but not be limited to African American, Native American, Hispanic, Asian, gay and lesbian populations \* \* \*. Bidders should discuss how

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<sup>19</sup> *Negotiating the New Health System*, *supra* note 1, at Vol. 2, Part 2, Table 3.6 (p. 3-200).

<sup>20</sup> *Id.*

<sup>21</sup> *Id.*

<sup>22</sup> *Id.* In most cases the definition tracks that used by Bazron and Scallet in their report.

<sup>23</sup> *Id.* (Hawaii behavioral health)

<sup>24</sup> *Id.* (Florida behavioral health)

they will work with the treatment program network to maintain culturally  
\* \* \* sensitive services.”<sup>25</sup>

Table 2 indicates that states that maintain both general and behavioral contracts are more likely to insert a general cultural competency provision in their behavioral agreements. However, while the behavioral contracts are more likely to contain such a provision, they are no more likely than the general agreements to define the term “cultural competence”, nor are they more likely to require specific types of conduct or practices as a measure of cultural competence. Of the ten documents that define the term “cultural competence,” three are specific to behavioral health.

Table 3 sets forth the cultural competence definitions found in the documents. The definition used in the Pennsylvania behavioral health agreement is the most comprehensive, both in the scope of its general definition as well as in the inclusion within the definition itself of specific illustrative applications of the definition.

### Specific Provisions Related to Cultural Competency

At the same time, a substantial number of states incorporate into their documents clear performance standards in one or more areas of cultural competence. Many agencies appear to have invested considerable time and effort in the development of performance standards; but far fewer have developed as part of their contracts specific methods for measuring performance.<sup>26</sup>

*New enrollee assistance.* Eleven documents specify assistance to new enrollees. The typical provision directs this assistance at new enrollees who do not speak English, as opposed to a more general provision to assist persons who have not only special language needs but also special cultural needs and preferences. For example, Illinois specifies that

The Contractor shall conduct all Enrollment activities in a language the eligible enrollee understands. Where that language is other than English, the Contractor shall offer and, if accepted by the Eligible Enrollee, shall supply interpretive services.<sup>27</sup>

On the other hand, Rhode Island’s new member specifications generally allude to an obligation to orient new members not only in an appropriate language but also in accordance with their cultural needs and preferences:

As part of its orientation process, Contractor shall hold informational “welcome” meetings for new members, that take into account the multi-

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<sup>25</sup> *Id.* (Iowa behavioral health)

<sup>26</sup> States may have separate quality measurement tools that measure clinical competence performance and that would be incorporated by reference into their contract documents.

<sup>27</sup> *Negotiating the New Health System*, *supra* note 1, at 3-201.

lingual, multi-cultural nature of the population.<sup>28</sup>

*Provider location.* Although location within ethnically and linguistically distinct communities is considered a key attribute of cultural competence, none of the contract documents specifies this level of geographic access as a precise specification. However, many documents do require inclusion of one or more classes of traditional and safety net providers (see discussion below). Frequently these providers are located in culturally and ethnically identifiable communities.

*Provider diversity.* Provider diversity performance specifications are relatively common, but the nature of the specification varies greatly from state to state. Twenty-five separate documents include one or more specifications related to the inclusion in networks of diverse providers. In most cases, the specification is limited to inclusion of one or more classes of “safety net” providers; overwhelmingly these safety net specifications are limited to federally qualified health centers (FQHCs).<sup>29</sup> A few states identify specific providers in the area of mental illness or addiction disorder treatment. For example, the Minnesota contract provides that plans

\*\*\* must subcontract with a children’s mental health collaborative organized under Minnesota statutes \*\*\* that has an integrated services system approved by the Children’s Cabinet, has entered into an agreement with the state to provide [Medicaid] services, is capable of providing inpatient and outpatient mental health services for an actuarial based capitation payment \*\*\* and requests to become a subcontractor.<sup>30</sup>

Oklahoma’s contract specifies that plans must contract with

\*\*\* at least one FQHC, one Urban Indian health center (within thirty miles or thirty minutes from a member’s residence where available) and one Title X family planning provider in each metropolitan area it serves.<sup>31</sup>

Note the ambiguity in the provision regarding the term “each metropolitan area”; it is unclear whether the phrase modifies one or all three classes of mandatory providers.

Rhode Island’s contract is an example of a broad diversity directive. The contract includes the following general diversity provision:

Contractor shall establish and maintain geographically accessible provider networks \*\*\* comprised of \*\*\* mental health providers [and] substance abuse providers \*\*\* in sufficient numbers to make available

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<sup>28</sup> *Id.* at 3-237.

<sup>29</sup> The Medicaid statute mandates FQHC services as a basic Medicaid service. As a result, HCFA requires states to specify that contractors include at least one FQHC in their networks or in the alternative demonstrate that they can furnish all FQHC services without inclusion of any health centers.

<sup>30</sup> *Negotiating the New Health System, supra* note 1, at 3-39.

<sup>31</sup> *Id.* at 3-60.

all services in a timely manner. In designing its network, Contractor shall take into account the multi-lingual, multi-cultural nature of the population to be served.<sup>32</sup>

While this provision requires Contractors to take these needs “into account”, it does not set any particular performance standard regarding inclusion, nor does it contain any intermediate or outcome specification regarding how the state will measure whether the contractor has in fact taken these factors into account in establishing its mental health network.

Virginia’s contract is notable for the elaborate manner in which the state ultimately describes a relatively ambiguous service obligation:

The Contractor \* \* \* is required to provide services to enrollees who require highly specialized or extensive treatment or rehabilitation and/or non-medical services for conditions of \* \* \* mental illness \* \* \*. The Contractor shall develop working relationships, described in memoranda of understanding or formal agreements, with community agencies that are involved in the provision of highly specialized or extensive treatment or rehabilitation and/or non-medical services to enrollees. [Contractor is responsible] for working cooperatively with other community agencies, providing or arranging for the provision of these services, and for treating the medical aspects of the above conditions as legitimate health care problems \* \* \*.<sup>33</sup>

Several aspects of this specification are worth noting. First, the Contractor is given the discretion to determine which enrollees fall into the category of requiring “highly specialized treatment or rehabilitation.” Since the Contractor’s relational duties with community programs are determined by this threshold issue, it is important to stress that the contractor thus has broad discretion in defining the scope of its relational obligations. Second, the term “working cooperatively” is left to the judgment of the contractor; similarly, use of the terms “memoranda” and “formal agreements” extend the contractor the latitude to develop a relationship that is other than a network agreement. This provision appears to have been drafted to specifically extend to contractors broad latitude in defining and implementing the scope of their provider diversity obligations.

*Language proficiency.* While many contracts contain general provisions related to provider diversity, a much smaller number require plans to include providers proficient in the language spoken by enrollees. The most notable examples are found in the Massachusetts and Nebraska documents, not only because of their clarity but also because of the intermediate performance measure they incorporate.

The Massachusetts general services contract provide as follows:

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<sup>32</sup> *Id.* at 3-65.

<sup>33</sup> *Id.* at 3-77.

The [health maintenance organization] will ensure that multi-lingual Providers are available for the most commonly used languages in a particular geographic area [the state identifies geographic service areas for its plans]. In such areas the HMO shall ensure that non-English speaking Enrollees shall have a choice of at least two (2) multi-lingual PCPs who can provide services to and speak to the enrollee in his or her primary language.

Measure: Provide an analysis of where enrollees who require multi-lingual services reside within the HMO's service area and provide a list of all multi-lingual [primary care physicians], by zip code, in the service area identified. Include the percentage of zip codes for which the HMO has a large concentration of multi-lingual enrollees but cannot meet the purchasing specifications.<sup>34</sup>

The Massachusetts provision is a good one for several reasons. First, it is unambiguous: the plan must be able to offer at least two PCPs who can communicate in specific ways. Second, the contract sets forth the measure the state uses. Third, the contractor is required to document not only how it will perform but where it *cannot* perform. The Massachusetts behavioral contract provides that:

The contractor shall ----

Execute provider agreements or enter into other arrangements for services only with providers that demonstrate that they \* \* \* are responsible to linguistic, cultural, and other unique needs of any minority, homeless person, disabled person, or other special population in the area in which they provide services, including the capacity to communicate with enrollees in language other than English, when necessary \* \* \*.

Maintain and update annually, at a minimum, the following data regarding providers'

Cultural and linguistic capabilities.<sup>35</sup>

While the behavioral health contract is somewhat broader than the general agreement, it nonetheless specifies capacity to communicate as well as the capacity to meet "unique needs" and requires at least an annual updating of culturally and linguistically proficient providers.

Like Massachusetts, Nebraska emphasizes inclusion of multi-lingual providers and specifies that plans must provide an analysis of their multilingual providers, including providers who speak "the three most common non-English language groups in the designated geographic areas defined by the state or its designee."<sup>36</sup>

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<sup>34</sup> *Id.* at 3-208.

<sup>35</sup> *Id.* at 3-209.

<sup>36</sup> *Id.* at 3-219.

*Literature/interpreter assistance.* With very few exceptions, all state contract documents contain provisions requiring the provision of interpretation services and literature that is translated into a variety of languages. The variation is enormous, however. First, the threshold for determining the obligation ranges broadly. The HCFA preamble noted above suggests a five percent threshold (i.e., services must be provided for cultural groups that represent at least five percent of the Medicaid population), one that historically was used by the Office for Civil Rights to measure language access compliance under Title VI of the 1964 Civil Rights Act. Numerous states, however, use a ten percent threshold test.<sup>37</sup> A few set the threshold at potentially a higher or lower level, because they use a numerical test. For example, the California contract provides as follows:

The Contractor will provide linguistic services to a population group of mandatory Medi-Cal enrollees residing in the proposed Service Area who indicate their primary language as other than English and who meet a numeric threshold of 3000, or a population group of mandatory Medi-Cal eligibles residing in the proposed 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.<sup>38</sup>

From a legal point of view, there are several notable ambiguities and problems in this specification if it is intended to serve as an assurance of linguistic access. First, the contractor arguably has no obligation unless the enrollees “indicate” a primary language other than English. Unlike Nebraska and Massachusetts, California effectively places the onus of identification not on the state or the contractor but on the enrollees themselves. Second, it is impossible to tell whether the duty to provide linguistic services depends on the number of *enrollees* in the service area or the number of *residents* of the service area. A service area can have thousands of residents whose primary language is other than English, and yet the contractor’s duty may not be triggered unless the threshold number enroll in the plan. Since some plans may be very small, the threshold number, when translated into a percentage of enrollment measure, could be 10 percent, 20 percent, or 50 percent.

A second issue is the scope of the obligation once the threshold test is met. California, for example, defines “linguistic services” as the following services “at key points of contact”: “interpreters, translated signage, translated written materials, and referrals to culturally and linguistically appropriate community service programs.”<sup>39</sup> Colorado, on the other hand, specifies interpreter services for assessment and treatment, member information, and advice regarding complaints and grievances.<sup>40</sup> A particularly interesting aspect of Colorado’s specification is the following requirement regarding access to interpreter services:

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<sup>37</sup> *Id.* (See annotations accompanying Table 3.6.)

<sup>38</sup> *Id.* at 3-192.

<sup>39</sup> *Id.* at 3-193.

<sup>40</sup> *Id.* at 3-194.

Whenever an individual because of a language or other communication barrier requests an interpreter in order to obtain covered services, the contractor shall provide the individual with access to an interpreter necessary to render effective health care consistent with generally accepted medical and surgical practices and standards prevailing in Colorado, if such interpreter services are reasonably available upon diligent effort by the contractor to obtain such services.<sup>41</sup>

This provision effectively sets a contractual standard of care that specifies that the contractor has a duty to obtain interpreter services if the interpretation is necessary to permit the contractor to meet the standard of care applicable to all health providers in the state. In order for the contractor to be shielded from malpractice for failure to furnish interpreter care, the contractor would have to affirmatively show that despite its “reasonable” efforts (presumably a factual question to be decided by a jury in a malpractice action), none could be found, thereby justifying substandard care.

Missouri has one of the most comprehensive sets of interpreter/materials specifications relating to individual member rights to file grievances and appeals, and it also sets a low threshold for triggering performance. The state specifies that:

Interpreter services shall be made available as necessary by telephone or in person to ensure that members are able to communicate with the health plan and providers and receive covered benefits. If the health plan has more than two hundred (200) members or five (5) percent of its program membership (whichever is less) who speak a single language other than English as a primary language, the health plan must agree to make available general services and materials, such as its member handbook, in that language \* \* \*.

The health plan must have a grievance procedure readily available in the member’s primary language. In addition, plans must demonstrate that they have procedures in place to notify all members in their primary language of their rights to file grievances and appeal grievance decisions by the plan.<sup>42</sup>

Nebraska provides additional specificity in its provisions while at the same time implicitly extending to a contractor the discretion to use a family member as interpreter in most situations, a practice that frequently is discredited:

Furthermore the HMO must provide for 24 hour a day, 7 days a week access to Spanish interpreters. Also, upon a client or provider request for interpreter services in a specific situation where care is needed the HMO shall make all reasonable efforts to provide an interpreter in time to assist adequately with all necessary care, including urgent and emergency care. Professional interpreters shall be used when needed where technical,

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<sup>41</sup> *Id.* at 3-195.

<sup>42</sup> *Id.* at 3-217.

medical or treatment information is to be discussed or where use of a family member or friend is inappropriate. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical.<sup>43</sup>

Minnesota has the most detailed performance measurement system in the area of interpreter and materials access:

The health plan agrees to submit to the state within 30 days of the effective date of this Contract the following information:

1. The process by which the health plan will assure availability of interpreter services for health care services for persons who do not speak English \* \* \*.
2. The names of agencies or services with which the health plan has contracts or agreements for interpreter services.
3. An explanation of how information about such services will be made available to providers with whom the health plan contracts; and
4. Any changes to the health plan's process described in this section or to provider contracts of agreements for interpreter services must be reported on a quarterly basis to the state.<sup>44</sup>

*Competency in treating gay and lesbian members or persons with special sexual/gender orientation-related needs.* Only the Iowa substance abuse contract contains any reference to the adaptation of services for gay or lesbian individuals.

*Cultural competency training.* Nine states specify cultural competency training as an ongoing plan duty. Generally, the training provisions are very general. For example, Kansas specifies that:

The HMO shall incorporate in its policies, administration, and service practice the value of (1) honoring members beliefs, (2) being sensitive to cultural diversity, and (3) fostering in staff/providers attitudes and interpersonal communication styles which respect members' cultural backgrounds. The HMO shall have specific policy statements on these topics and communicate them to subcontractors.

The HMO shall encourage and foster cultural competency among providers.<sup>45</sup>

This provision would permit the state to request and inspect the policy statements as well as the HMO's policies, administration, and service practice directives, to determine the level of cultural competency training.

*Alternative medicine and medical necessity.* Only in the case of Pennsylvania does a state

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<sup>43</sup> *Id.* at 3-219.

<sup>44</sup> *Id.* at 3-213.

<sup>45</sup> *Id.* at 3-205.

address cultural diversity in a coverage context. In Pennsylvania’s case, the reference to cultural considerations occurs within the cultural competency provisions rather than the coverage provisions of the contract. Thus, the effect of the provisions is difficult to ascertain. The cultural competency provision specifies as follows:

Both the HMO and participating providers must demonstrate cultural competency and must understand that cultural differences (between provider and patient) cannot be permitted to present barriers to accessing and receiving quality health care; willingness and ability to make the necessary distinctions between traditional treatment methods and/or non traditional treatment methods that are consistent with the patient’s cultural background and which may be equally or more effective and appropriate for the particular patient; and the demonstration of consistency in providing quality care across a variety of culture. For example, language, religious beliefs, cultural norms, social-economic conditions, diet, moral code, etc. may make one treatment method more palatable to a patient of a particular culture than to another of a differing culture.<sup>46</sup>

*Administration, performance measurement, and payment.* As Table 1 demonstrates, far fewer states focus on administration than access to covered services. A very limited number specify performance standards such as those set forth above. Nebraska is the only state to use a consumer satisfaction measure as part of its means for measuring compliance with the language elements of its contract’s cultural competency standards, and as drafted, its measurement (eighty percent member satisfaction rates)<sup>47</sup> is ambiguous regarding whether the denominator is the entire plan membership or only those members whose primary language is not English.

No state appears to specify separate payment provisions for cultural competency services.

## **Conclusion**

This review suggests that as a general matter, states understand the need to focus on the collection of matters known as “cultural competence” in their contracts, but that as with other issues in Medicaid, state responses vary widely. Federal law provides states with considerable discretion in the area of cultural competence but does establish proposed regulatory requirements in the areas of linguistic access to information and access to care. These requirements are in addition to federal regulatory standards applicable to publicly assisted programs under Title VI of the 1964 Civil Rights Act, which has been held to apply to language as well as race and national origin.

A review of the contract data base suggests that many states address language issues

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<sup>46</sup> *Id.* at 3-234.

<sup>47</sup> *Id.* at 3-224.

related to cultural competency through inclusion of relatively general provisions regarding interpreters and information materials. Some states go beyond information and basic access and include other issues such as plan administration (including grievances and complaints) and access to both basic and specialty care. Most states do not address other dimensions of the cultural competence question as it affects areas beyond language (e.g., sexual orientation, religious beliefs, cultural beliefs) except in relatively hortatory ways.

Most interesting perhaps is the complete or near absence of certain elements of cultural competency, such as the geographic location of services in ethnically distinct neighborhoods and the presence of bilingual providers. States may assume that they have little ability to affect these matters and that this type of access is more of a function of the underlying health care system in which their contractors work. More difficult to understand is the absence of extensive requirements in the area of plan administration itself, such as accessible complaint and grievance procedures.

Of enormous importance is the wide range that can be seen in the contracts in threshold points that states use to trigger their contractors' obligations, whatever they may be. Even exhaustive and detailed standards have little meaning if the threshold level at which they are triggered is so high that few if any contractors would be affected. In other words, if a contractor has no duty until, say, a 10 percent membership threshold is reached, then even detailed performance standards would potentially have little effect.

This analysis suggests a need for substantial technical assistance in this area. Purchasers may benefit from efforts to identify the range of factors that comprise cultural competency, sample specification language delineating alternative approaches to each factor, and alternative approaches to the issue of thresholds. Which standards should apply only if the concentration of members in need of cultural competency assistance is relatively high? Which should be triggered even if the number of enrollees in need of assistance is moderate? Which if any cultural competency services should be required regardless of the level of enrollment. These are difficult questions but should all be considered in an effort to operationalize cultural competence performance standards. In addition, assistance is needed to identify means for measuring performance.

Finally, the issue of cultural competency underscores the fact that the accessibility and quality of care offered by today's managed care plans may be as much a feature of the underlying health system as their ability to influence it. The modern MCO is not a brick and mortar affair: it is a virtual system tied to its network of providers and suppliers through a cascade of contracts and subcontracts. Purchasers that wish to have culturally competent managed care probably also need to be concerned about the well-being and survival of the underlying health system on which it is built and might wish to consider direct investment in cultural competency improvement strategies.