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Health Forum

## **CULTURAL AND LINGUISTIC REQUIREMENTS IN MEDICAID MANAGED CARE**

On June 14, 2002, the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) published a final rule to regulate the managed care portion of the Medicaid program, and to allow states to enroll beneficiaries into Medicaid managed care without obtaining a federal waiver. These regulations contain a number of requirements for the provision of culturally and linguistically (C/L) appropriate care to Medicaid beneficiaries. These include requirements for states and managed care organizations (MCOs) to; make written materials available in prevalent non-English languages, make oral interpretation available in any language, and notify enrollees on the availability of oral interpretation and written translation services. The regulations also include important requirements for data collection, and participation in state efforts to improve cultural competency. The regulations became effective on August 13, 2002, and states are required to be in full compliance by June 16, 2003.

### **Cultural and Linguistic Competence Requirements in the June 2002 Final Rule**

#### **Subpart A – General Provisions**

##### **§ 438.10 Information requirements. (See Appendix A for full text)**

This section calls for the state and managed care organizations to provide information to enrollees<sup>1</sup> and potential enrollees<sup>2</sup> in a manner that may be easily understood.

#### **Basic Rules:**

Each State, enrollment broker, Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP), and Primary Care Case Management (PCCM) must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.

The State must have in place a mechanism to help enrollees and potential enrollees understand the State's managed care program.

Each MCO and PIHP must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.

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<sup>1</sup> Enrollees are defined as “a Medicaid recipient who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program.”

<sup>2</sup> Potential enrollees are defined as “a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, or PCCM.”

In particular, each state must:

- (1) Establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State. “Prevalent” means a non-English language spoken by a significant number or percentage of potential enrollees and enrollees in the State.
- (2) Make available written information in each prevalent non- English language.
- (3) Require each MCO, PIHP, PAHP, and PCCM to make its written information available in the prevalent non-English languages in its particular service area.
- (4) Make oral interpretation services available and require each MCO, PIHP, PAHP, and PCCM to make those services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent.
- (5) Notify enrollees and potential enrollees, and require each MCO, PIHP, PAHP, and PCCM to notify its enrollees—(i) That oral interpretation is available for any language and written information is available in prevalent languages; and (ii) How to access those services.

**Format:**

- (1) Written materials must (i) use easily understood language and format; and (ii) be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
- (2) All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

The regulation also specifies what types of information are required to be provided to enrollees and potential enrollees and when that information must be provided. Among other things, all enrollees must be provided with “names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee’s service area...”

**Subpart D – Quality Assessment and Performance Improvement**  
**§ 438.204 Elements of State quality strategies. (See Appendix B for full text)**

This section requires each state’s quality strategy to “identify the race, ethnicity, and primary language spoken of each Medicaid enrollee.” Furthermore, states must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.

**Subpart D – Quality Assessment and Performance Improvement**  
**§ 438.206 Availability of services. (See Appendix C for full text)**

This section requires that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs. In particular, states must ensure that “each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.” While this does not specifically mandate the delivery of culturally competent services by managed care organizations, it does strengthen the authority of states to implement programs and requirements for the provision of these services.

**Deleted Requirements**

While the June 2002 final rule contains important provisions that could produce widespread changes in services provided to Medicaid beneficiaries, it is a step backward compared to previous versions of the rule. Most notably, CMS published a proposed rule on September 29, 1998; a final rule on January 19, 2001 (which was never allowed to go into effect); and a proposed rule on August 20, 2001. These previous versions contain differences in some of the requirements for culturally and linguistically appropriate care.

**§438.10 Information Requirements:** While previous versions of this provision requires the state to “**provide** written information in each prevalent non-English language”, the June 2002 final rule only requires the state to “**make available** written information in each prevalent non-English language.”

**§438.102 Provider-enrollee communications:** The January 19, 2001 rule contained a statement that “MCOs and PHPs must take steps to ensure that health care professionals...furnish information about treatment options (including the option of no treatment) in a culturally competent manner...” This requirement has been eliminated.

**§438.206 Availability of services:** Previous iterations required states to ensure that “each MCO and each PHP ensures that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.” This requirement has been eliminated.

**§438.240 Quality assessment and performance improvement program:** This section requires each MCO and prepaid inpatient health plan (PIHP) to have an ongoing quality assessment and performance improvement program. The January 2001 final rule specified “cultural competence” as one of the options that MCOs and PIHPs would be required to choose from. This was not included in the June 2002 final rule.

## Appendix A

### Sec. 438.10 Information requirements.

(a) Terminology. As used in this section, the following terms have the indicated meanings: Enrollee means a Medicaid recipient who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program. Potential enrollee means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP, PAHP, or PCCM.

(b) Basic rules.

(1) Each State, enrollment broker, MCO, PIHP, PAHP, and PCCM must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.

(2) The State must have in place a mechanism to help enrollees and potential enrollees understand the State's managed care program.

(3) Each MCO and PIHP must have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan.

(c) Language. The State must do the following:

(1) Establish a methodology for identifying the prevalent non- English languages spoken by enrollees and potential enrollees throughout the State. ``Prevalent" means a non-English language spoken by a significant number or percentage of potential enrollees and enrollees in the State.

(2) Make available written information in each prevalent non- English language.

(3) Require each MCO, PIHP, PAHP, and PCCM to make its written information available in the prevalent non-English languages in its particular service area.

(4) Make oral interpretation services available and require each MCO, PIHP, PAHP, and PCCM to make those services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent.

(5) Notify enrollees and potential enrollees, and require each MCO, PIHP, PAHP, and PCCM to notify its enrollees—(i) That oral interpretation is available for any language and written information is available in prevalent languages; and (ii) How to access those services.

(d) Format.

(1) Written material must—

(i) Use easily understood language and format; and

(ii) Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

(2) All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

(e) Information for potential enrollees.

(1) The State or its contracted representative must provide the information specified in paragraph (e)(2) of this section to each potential enrollee as follows:

(i) At the time the potential enrollee first becomes eligible to enroll in a voluntary program, or is first required to enroll in a mandatory enrollment program.

(ii) Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs, PIHP, PAHPs, or PCCMs.

(2) The information for potential enrollees must include the following:

(i) General information about-- (A) The basic features of managed care; (B) Which populations are excluded from enrollment, subject to mandatory enrollment, or

- free to enroll voluntarily in the program; and (C) MCO, PIHP, PAHP, and PCCM responsibilities for coordination of enrollee care;
- (ii) Information specific to each MCO, PIHP, PAHP, or PCCM program operating in potential enrollee's service area. A summary of the following information is sufficient, but the State must provide more detailed information upon request: (A) Benefits covered. (B) Cost sharing, if any. (C) Service area. (D) Names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs, this includes at a minimum information on primary care physicians, specialists, and hospitals.
- (f) General information for all enrollees of MCOs, PIHPs, PAHPs, and PCCMs. Information must be furnished to MCO, PIHP, PAHP, and PCCM enrollees as follows:
- (1) The State must notify all enrollees of their disenrollment rights, at a minimum, annually. For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 days before the start of each enrollment period.
  - (2) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must notify all enrollees of their right to request and obtain the information listed in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least once a year.
  - (3) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must furnish to each of its enrollees the information specified in paragraph (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, within a reasonable time after the MCO, PIHP, PAHP, or PCCM receives, from the State or its contracted representative, notice of the recipient's enrollment.
  - (4) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must give each enrollee written notice of any change (that the State defines as "significant") in the information specified in paragraphs (f)(6) of this section and, if applicable, paragraphs (g) and (h) of this section, at least 30 days before the intended effective date of the change.
  - (5) The MCO, PIHP, and, when appropriate, the PAHP or PCCM, must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.
  - (6) The State, its contracted representative, or the MCO, PIHP, PAHP, or PCCM must provide the following information to all enrollees: (i) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs this includes, at a minimum, information on primary care physicians, specialists, and hospitals.

## Appendix B

### Sec. 438.204 Elements of State quality strategies.

At a minimum, State strategies must include the following:

- (a) The MCO and PIHP contract provisions that incorporate the standards specified in this subpart.
- (b) Procedures that—
  - (1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.
  - (2) Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.
  - (3) Regularly monitor and evaluate the MCO and PIHP compliance with the standards.
- (c) For MCOs and PIHPs, any national performance measures and levels that may be identified and developed by CMS in consultation with States and other relevant stakeholders.

- (d) Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO and PIHP contract.
- (e) For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.
- (f) An information system that supports initial and ongoing operation and review of the State's quality strategy.
- (g) Standards, at least as stringent as those in the following sections of this subpart, for access to care, structure and operations, and quality measurement and improvement.

## **Appendix C**

### **Sec. 438.206 Availability of services.**

- (a) Basic rule. Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs.
- (b) Delivery network. The State must ensure, through its contracts, that each MCO, and each PIHP and PAHP consistent with the scope of the PIHP's or PAHP's contracted services, meets the following requirements:
  - (1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, each MCO, PIHP, and PAHP must consider the following:
    - (i) The anticipated Medicaid enrollment.
    - (ii) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the particular MCO, PIHP, and PAHP.
    - (iii) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.
    - (iv) The numbers of network providers who are not accepting new Medicaid patients.
    - (v) The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.
  - (2) Provides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.
  - (3) Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.
  - (4) If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP, or PAHP must adequately and timely cover these services out of network for the enrollee, for as long as the MCO, PIHP, or PAHP is unable to provide them.
  - (5) Requires out-of-network providers to coordinate with the MCO or PIHP with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.
  - (6) Demonstrates that its providers are credentialed as required by Sec. 438.214.
- (c) Furnishing of services. The State must ensure that each MCO, PIHP, and PAHP contract complies with the requirements of this paragraph.
  - (1) Timely access. Each MCO, PIHP, and PAHP must do the following:

(i) Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.

(ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

(iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.

(iv) Establish mechanisms to ensure compliance by providers.

(v) Monitor providers regularly to determine compliance.

(vi) Take corrective action if there is a failure to comply.

(2) Cultural considerations. Each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.