



## Do HMOs Help or Hinder Access for Children with Special Health Care Needs from Limited English-Proficient Families?

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Families of children with special health care needs (SHCN) stemming from chronic physical, developmental, behavioral, or emotional conditions can be overwhelmed by the challenge of finding the right care at the right time and paying for it. For parents from diverse cultural backgrounds or with limited English proficiency (LEP), obtaining care for their SHCN children may be even more challenging. Cumulatively, studies on health care barriers for minority children suggest that children in LEP homes may suffer the highest level of health care disparities.

A managed care environment may ameliorate these difficulties by offering SHCN children and their families a regular source of primary care, referrals to appropriate services, and other practices that improve access and care management. However, certain aspects of managed care, such as gatekeeping and limited provider choice, may undermine these benefits and hinder access to services.

### Methods

The 2003 California Health Interview Survey (CHIS) offers an opportunity to study specific managed care plans, including their characteristics and the effect of their characteristics on access to health care for SHCN children by their parents' race/ethnicity and English proficiency. CHIS is a geographically stratified, random-digit dial (RDD) telephone survey of 42,000 households drawn from nearly every county in California. The CHIS sample is representative of California's non-institutionalized population and includes all major ethnic groups and several ethnic subgroups. The 2003 survey was conducted in English, Spanish, Chinese (Mandarin and Cantonese), Vietnamese, and Korean.

We examined the CHIS 2003 child data set to learn about SHCN children from birth to age 11. We studied the children's access to care and how access is affected by their parents' race/ethnicity, English language

proficiency, and enrollment in managed care plans. Access measures included having a usual source of medical care, having a treatment or prescription delayed or denied for cost reasons, and the number of doctor visits in the past 12 months. Survey data were weighted using the weights provided in the data set to simulate the California population.

The relationship between race/ethnicity, English-language proficiency, and access to care was examined in multivariate regression equations controlling for other factors that could affect access, such as having insurance, parents' level of education, and family income.

### Findings

#### *Characteristics of SHCN Children*

- There were 968,000 children (16% of all children) with SHCN according to screening criteria included in the CHIS survey questions.
- By race/ethnicity, 46% were white, 33% were Hispanic, 10% were African American, 6% were Asian, 3% were some other race/ethnicity or mixed, and 2% were American Indian/Alaskan Native (AIAN).
- Seventeen percent of the SHCN children had parents with limited English proficiency (LEP), compared to 24% of children with LEP parents in the general population.

#### *Enrollment of SHCN Children in Health Care Plans*

- Seventeen percent were enrolled in Blue Cross, 14% in Kaiser Permanente, and 13% in Medicare or Medi-Cal. For the majority of children, the insurer was either some other smaller health plan (27%) or unknown (18%).
- One-third of the SHCN children from LEP families were enrolled in Medi-Cal or Medicare. This was an overrepresentation in publicly sponsored plans which may be due to these children's greater poverty or to the greater willingness of public providers to serve LEP families.
- Approximately 69% of all SHCN children and 61% of LEP children were enrolled in health plans requiring the identification of a

primary care physician or medical group, and requiring prior approval to see a specialist.

### *SHCN Children's Access to Care*

- Five percent of all SHCN children had no usual source of medical care. By ethnicity, AIAN (11%), Asian (9%), and Latino (8%) children had the highest rates of no usual source of care. Among children with LEP parents, 11% had no usual source of care.
- Nine percent of all SHCN children had treatments or prescriptions delayed or denied for cost reasons. AIAN children (17%), children with LEP parents (12%), and Latino children (10%) had the highest rates of care being delayed or denied for cost reasons.
- Four percent of all SHCN children had no doctor visits in the past 12 months. Children from LEP families (14%) and Latino children (9%) had the highest proportion of children in this group.
- Comparing access to health care for SHCN children of either white or Latino ethnicity in LEP and non-LEP families, we found the following:
  - All three access measures were significantly worse for children of LEP parents compared to children of non-LEP parents.
  - Controlling for LEP and socioeconomic factors, children of Latino parents had slightly better or similar measures of access compared to children of white parents.

### *Managed Care Characteristics and Access to Health Care*

- For white and Latino SHCN children enrolled in health plans requiring assignment to a primary care physician or medical group, the requirement increased the odds of having a usual source of care, but also increased the odds of care being delayed or denied for cost reasons. There was no effect on the number of visits in the past 12 months. This finding seems to be in keeping with the goals of managed care: to encourage the use of lower-cost preventive or health maintenance care, to reduce more expensive crisis care, and to have the primary care physician act as a gatekeeper to more expensive specialists.
- For SHCN children with white or Latino LEP parents, enrollment in a health plan requiring assignment to a primary care physician or

medical group actually reduced the odds of having a usual source of care. This finding is consistent with previous studies showing that these requirements reduce plan member affiliation and relationship, perhaps due to the lack of linguistic and racial/ethnic concordance between LEP enrollees and network providers. These health plan requirements, however, did not appear to result in greater delay/denial of care or fewer visits in the past 12 months.

- Among white and Latino SHCN children in general, health plans' requirements of prior approval to see a specialist increased the odds of having a usual source of care and of having care delayed or denied for cost reasons, but had no significant effect on the number of visits per child in the past 12 months.
- For SHCN children with white or Latino LEP parents, the requirement for prior approval to see a specialist increased the odds of having a usual source of care, bringing the odds for the LEP population closer to the odds for the non-LEP population. The requirement for prior approval also increased the odds of delay or denial of care, making the very high odds of delay/denial for the LEP population even higher. However, prior approval had no effect on the number of visits per child in the past 12 months.

### **Policy Implications and Recommendations**

- With the implementation of Medi-Cal Redesign, the state is increasing the portion of Medi-Cal enrollees served in managed care settings. Given the large portion of LEP families enrolled in Medi-Cal, this policy change will move many LEP families, who already have trouble accessing care, into managed care settings. This shift to managed care will probably reduce these children's likelihood of having a usual source of care and increase delays and denials of their care unless action is taken to remove the barriers created by managed care systems.
- Since the requirements to identify a primary care physician or medical group and to obtain prior approval to see a specialist had no significant effect on the number of visits per child, managed care plans may consider relaxing these restrictions in some fashion for SHCN children, particularly those from LEP

families. Doing so might increase the usual source of care and reduce delays in receiving needed treatment, thereby improving overall quality of care for these children without increasing costs to the plans.

- Managed health care plans should be encouraged to aggressively increase the number of bilingual professionals that they have available to serve the LEP population of SHCN children. Linguistic and ethnic concordance between enrollees and providers will improve the likelihood that this underserved population can gain access to a usual source of care and receive more effective and efficient services.
- State and local governments must also aggressively enforce Title VI requirements ensuring equal access to services for persons whose primary language is not English. It is particularly important that the Department of Health Services enforce these laws within contracted health plans serving the Medi-Cal-eligible population, given that Medi-Cal is the single largest health insurer for LEP populations in the state.

There are fiscal and contractual incentives that the state could employ to help managed care plans reach these goals, at least for Medi-Cal enrollees. They include the following:

- Allow health plans or medical groups to bill for interpreter services.
- Reimburse plans that provide more bilingual services at a premium.
- Contractually require a minimum number of bilingual providers or interpreters per LEP enrollee in each geographic area served.

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