Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

GUIDANCE AND STANDARDS ON LANGUAGE ACCESS SERVICES: MEDICARE PLANS

Daniel R. Levinson
Inspector General

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EXECUTIVE SUMMARY

OBJECTIVES

1. To determine the extent to which Medicare plans conducted the four-factor assessment recommended by the Office for Civil Rights' (OCR) guidance when determining what language access services to offer.

2. To determine the extent to which Medicare plans offered language access services consistent with the Office of Minority Health's (OMH) Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards on language access services.

3. To determine the extent to which Medicare plans realized benefits, including savings, and encountered obstacles to providing language access services.

4. To describe costs of providing language access services.

BACKGROUND

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires that the Office of Inspector General (OIG) conduct a study examining Medicare provider and plan compliance with (1) OCR's *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* (hereinafter referred to as OCR guidance) and (2) OMH's CLAS standards. The MIPPA also requires that OIG describe the costs or savings related to the provision of language access services.

Because OCR guidance and CLAS standards are not mandatory, OIG assessed Medicare plans' voluntary compliance as indicated by the extent to which Medicare plans conducted the four-factor assessment recommended by OCR guidance and offered language access services consistent with CLAS standards. A companion report, *Guidance and Standards on Language Access Services: Medicare Providers* (OEI-05-10-00050), provides the same assessment for Medicare providers.

The Centers for Medicare & Medicaid Services (CMS) contracts with private companies to provide health insurance plans under Medicare Advantage, stand-alone prescription drug plans under Part D (hereinafter referred to collectively as plans), or both. Plans typically administer benefits by contracting with direct service providers, such as

hospitals, nursing homes, and pharmacies. Thus, most of plans' direct contact with beneficiaries is through call centers and marketing materials.

OCR guidance and CLAS standards address the provision of language access services. OCR guidance recommends that plans conduct a four-factor assessment to help determine what language access services to offer. These factors are (1) the number or proportion of Limited English Proficient (LEP) persons eligible to be served or likely to be encountered in the provider's service population; (2) the frequency with which LEP persons come in contact with the provider; (3) the importance, nature, and urgency of the program, activity, or service to people's lives; and (4) the resources available to the provider and costs for offering language access services.

OMH's CLAS standards can help plans become responsive to the cultural and linguistic needs of diverse populations. Four of the fourteen CLAS standards focus on the provision of language access services. These standards are (1) providing language access services during all business hours, (2) providing verbal offers and written notices of the right to language access services, (3) assuring the competence of language assistance provided by staff, and (4) providing written materials and signage translated into appropriate languages.

Language access services are designed to promote effective communication between LEP persons and non-LEP persons. LEP persons do not speak English as their primary language and have a limited ability to read, write, speak, or understand English. Language access services can include oral interpretation and written translation.

To conduct this review, we administered a survey in 2009 to 139 randomly selected plans operating in counties with a high percentage of LEP persons.

FINDINGS

Eighty-eight percent of plans conducted the four-factor assessment recommended by OCR guidance when determining what language access services to offer. Eighty-eight percent of plans conducted all four factors of the recommended assessment. The remaining plans considered three of the factors. The percentages of plans that completed each of the individual factors ranged between 94 percent and 100 percent.

Sixty-seven percent of plans offered services consistent with all four CLAS standards on language access services. Although all plans reported offering some language access services, only 67 percent of plans offered services consistent with all four CLAS standards on language access services. The percentages of plans that offered services consistent with each of the individual standards ranged between 71 percent and 99 percent. Plans were least likely to inform LEP persons both verbally and in writing of their right to receive language access services.

Only 49 percent of plans reported benefits to providing language access services and 57 percent reported obstacles. The most frequently reported benefit was improved communication with LEP persons. The three most frequently reported obstacles included the costs of providing language access services, identifying LEP persons, and lack of staffing for providing language access services.

Although 79 percent of plans reported data on the costs of providing language access services, these data were not comparable. Of the 135 plans that responded to the survey, 106 reported cost data. However, plans' comments about how they calculated costs indicated different approaches to calculating costs. Because of these differences, we were unable to make determinations about costs of language access services.

RECOMMENDATION

The MIPPA requires OIG to make recommendations on improving compliance with and enforcement of CLAS standards. However, in keeping with our assessment of voluntary compliance, we make a recommendation to increase the percentage of plans that voluntarily offer services consistent with all four CLAS standards on language access services.

We recommend that:

- **OMH collaborate with CMS to inform plans that they should notify LEP persons both verbally and in writing of their right to receive language access services.**

AGENCIES' COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

OMH and CMS both concurred with our recommendation. OMH stated that it will work closely with CMS to inform plans that they should inform LEP persons both verbally and in writing of their rights to receive language access services. CMS reiterated its goal to provide clear, accurate, and timely information about language access services.

TABLE OF CONTENTS

INTRODUCTION

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1. To determine the extent to which Medicare plans conducted the four-factor assessment recommended by the Office for Civil Rights' (OCR) guidance when determining what language access services to offer.

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Because OCR guidance and CLAS standards are not mandatory, OIG could not assess compliance or make recommendations on the enforcement of CLAS standards. Instead, OIG assessed Medicare plans' voluntary compliance, as indicated by the extent to which plans

[1] Although the OCR guidance was signed by the then-Director of OCR, it was issued on behalf of the Secretary of Health & Human Services (HHS) and applies to all entities receiving funds from HHS.

[2] P.L. 110-275 § 187 (July 15, 2008), 42 U.S.C. § 1395cc note.

conducted the four-factor assessment recommended by OCR guidance and offered language access services consistent with CLAS standards.

This report is one of two reports issued in response to the MIPPA provision. A companion report, *Guidance and Standards on Language Access Services: Medicare Providers* (OEI-05-10-00050), focuses on Medicare providers, such as hospitals and nursing homes, which directly supply heath care services to beneficiaries.

Medicare Plans

The Centers for Medicare & Medicaid Services (CMS) contracts with private companies to provide health insurance plans under Medicare Advantage, stand-alone prescription drug plans under Part D (hereinafter referred to collectively as plans), or both. Private companies may choose to provide both Medicare Advantage and stand-alone prescription drug plans. As of February 2010, more than 29 million Medicare beneficiaries were enrolled in Medicare Advantage and stand-alone prescription drug plans.[3]

Plans receive a monthly prospective payment from CMS to cover their estimated costs for providing services to Medicare beneficiaries. In calculating these payments, CMS allows plans to report all of their administrative costs to operate plans.[4] According to CMS staff, administrative costs include such things as translating marketing materials and operating call centers.[5]

Plans have limited direct contact with beneficiaries. These plans typically administer benefits by contracting with direct service providers, such as hospitals, nursing homes, and pharmacies. Thus, most of plans' direct contact with beneficiaries is through call centers and marketing materials.

Language Access Services for Limited English Proficient Persons

Language access services are designed to promote effective communication between Limited English Proficient (LEP) persons and

[3] CMS, *Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Medicare Plan Contract Report - Monthly Summary Report,* March 2010. Accessed at http://www.cms.hhs.gov on March 31, 2010.

[4] CMS, *Instructions for Completing the Medicare Advantage Bid Pricing Tool and the Medical Savings Account Bid Pricing Tool for Contract Year 2010*, Pub. No. 10142. Accessed at http://www.cms.hhs.gov on February 17, 2010.

[5] Medicare plans must operate call centers that Medicare beneficiaries can contact to speak with a customer service representative to answer questions concerning, for example, enrollment, benefits, costs, or coverage.

non-LEP persons.[6] LEP persons do not speak English as their primary language and have a limited ability to read, write, speak, or understand English.[7] According to the U.S. Census Bureau, approximately 18 percent of the U.S. population in 2000 spoke languages other than English at home. Further, 8 percent of the U.S. population, or approximately 21 million people, spoke English less than "very well."[8]

Language access services may include oral interpretation; written translation; and other provisions that enhance communication, such as translated signage.[9] In providing oral interpretation plans may choose, for example, to hire bilingual staff, to contract with interpreters, or to use telephone interpreter lines. When providing written translation, for example, plans may translate marketing materials or benefit explanation materials.

The lack of language access services enables language barriers to persist between LEP persons and non-LEP staff at plans, which can lead to problems for LEP persons. Congressional testimony suggests that LEP beneficiaries have had problems with plan call centers resulting from language barriers.[10] Problems included failure to connect LEP persons to interpreters or interpreters who were not knowledgeable or able to answer questions.[11]

Title VI of the Civil Rights Act

Title VI of the Civil Rights Act of 1964, as amended, provides that no person in the United States shall "on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."[12] The Supreme Court has

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[6] OMH, *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*, p. 1. Accessed at http://minorityhealth.hhs.gov on January 15, 2010.

[7] OCR, *Guidance*, pt. IV, 68 Fed. Reg. 47311, 47313 (Aug. 8, 2003). Accessed at http://www.hhs.gov/ocr on October 21, 2009.

[8] U.S. Census Bureau, *Profile of Selected Social Characteristics: 2000*. Accessed at http://factfinder.census.gov on January 15, 2010.

[9] OMH, *Patient-Centered Guide*, loc. cit.

[10] California Health Advocates, *Medicare Part D: Implementation of the New Drug Benefit*, written testimony before the U.S. House of Representatives, Committee on Energy and Commerce, Hearing by the Subcommittee on Health, March 1, 2006. Accessed at http://www.cahealthadvocates.org on March 2, 2010.

[11] Ibid.

[12] P.L. 88-352 § 601; 42 U.S.C. § 2000d.

interpreted the Title VI implementing regulation to find that conduct with a disproportionate effect on LEP persons had a discriminatory impact on the basis of national origin.[13]

OCR Oversight of Title VI Compliance

OCR is the civil rights law enforcement agency for HHS. As such, it ensures that all recipients of Federal financial assistance through HHS, including plans, operate their programs in compliance with Federal civil rights laws. Federal financial assistance includes grants, training, use of equipment, donation of surplus property, and other assistance.[14]

OCR enforces compliance with Title VI by investigating complaints of discrimination. According to OCR staff, of the 17 complaints concerning LEP persons received in fiscal year (FY) 2009, 1 complaint involved plans. If OCR investigates and determines that discrimination has occurred, a plan usually has 60 days to correct the violation or provide OCR with a plan of correction.[15] OCR staff stated that they strive for voluntary compliance and resolution in all cases, as required by Title VI. Accordingly, complaints are often voluntarily resolved through an exchange of letters containing requirements for improvement.

OCR Guidance for Determining What Language Access Services To Offer

In August 2000, OCR, on behalf of the Secretary of HHS, issued guidance specifically concerning discrimination affecting LEP persons.[16] The guidance was issued in response to an August 2000 Executive Order requiring Federal agencies to clarify and publish guidance on Title VI requirements.[17] The original guidance was republished in February 2002, seeking public comment.[18] In 2003, after receiving public comments and subsequent guidance from the U.S. Department of Justice, OCR issued revised guidance.[19]

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[13] Lau v. Nichols. 414 U.S. 563 (1974).

[14] 45 CFR § 80, App. A.; 45 CFR § 80.2.

[15] OCR, *How Does OCR Investigate a Civil Rights Complaint?* Accessed at http://www.hhs.gov/ocr on February 25, 2010.

[16] 65 Fed. Reg. 52762 (Aug. 30, 2000).

[17] Executive Order 13166, *Improving Access to Services for Persons with Limited English Proficiency*, 65 Fed. Reg. 50121 (Aug. 16, 2000).

[18] 67 Fed. Reg. 4968 (Feb. 1, 2002).

[19] OCR, *Guidance,* introduction at 47311.

OCR guidance is meant to assist recipients of HHS financial assistance, including plans, in ensuring meaningful access for LEP persons to critical services while not imposing an undue burden. OCR guidance does not carry the force of law and is not mandatory.[20]

OCR guidance recommends that each recipient of HHS financial assistance determine what language access services to offer by conducting a four-factor assessment. The four factors are:[21]

(1) the number or proportion of LEP persons eligible to be served or likely to be encountered in the recipient's service population;

(2) the frequency with which LEP persons come in contact with the recipient;

(3) the importance, nature, and urgency of the program, activity, or service to people's lives; and

(4) the resources available to the recipient and costs for offering language access services.

After conducting the four-factor assessment, recipients have discretion to determine what language access services to offer. In some cases, offering language acccess services may not be necessary to comply with Title VI.[22] However, this discretion does not diminish, and should not be used to minimize, recipients' obligation to address the needs of LEP persons.[23]

OMH's CLAS Standards

In 2001, OMH created the CLAS standards to provide consistent and comprehensive guidance to promote cultural and linguistic competence in health care. As is OCR guidance, the CLAS standards are not mandatory.[24]

OMH divided the standards into three categories: Culturally Competent Care (standards 1–3), Language Access Services (standards 4–7), and Organizational Supports for Cultural Competence

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[20] OCR, *Guidance*, pt. III at 47313, footnote 2.

[21] Ibid., pt. V at 47314.

[22] Ibid.

[23] Ibid.

[24] According to OMH officials, the four Language Access Services standards are not mandatory despite language stating that they are Federal requirements and that health care organizations "must" provide the services noted in each of the four standards.

(standards 8–14).[25] For a list of all 14 CLAS standards, see Appendix B.

The four Language Access Services standards are:[26]

Standard 4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

OMH staff offer training and educational resources related to CLAS standards to plans through its Center for Cultural and Linguistic Competence in Health Care (the Center).[27] Established in FY 1995, the Center was OMH's response to the Disadvantaged Minority Health Improvement Act of 1990 and encouragement from Congress to establish a center to develop and evaluate models, conduct research, and provide technical assistance to providers on removing language barriers to health care services.[28]

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[25] OMH, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, p. 3. Accessed at http://minorityhealth.hhs.gov on January 15, 2010.

[26] Ibid., pp. 10–13.

[27] OMH, *About the Center for Cultural and Linguistic Competence in Health Care*. Accessed at http://minorityhealth.hhs.gov/ on March 8, 2010.

[28] H.R. Rep. No. 103-553 at 54 (1994).

Through the Center, OMH offers training and educational resources related to the provision of language access services. This includes accredited training programs for physicians, nurses, and disaster personnel on cultural competency through e-learning programs. OMH also publishes *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*, which was designed to help health care administrators and organizations comply with Title VI and implement the CLAS standards.[29] In addition, OMH distributes an e-newsletter that is geared toward all persons interested in cultural competency in health care settings.

CMS Guidance Supporting Language Access Services

CMS has published marketing guidelines establishing that plans must provide interpretation and translation services to LEP persons.[30] Although OCR guidance allows discretion when determining what language access services to offer, CMS requires plans to offer at least some language access services.

Three of CMS's marketing guidelines correspond closely to CLAS Standards 4 and 7 and partially to CLAS Standard 5. Specifically, CMS guidelines state that plans' call centers must accommodate LEP persons and provide service to LEP persons during business hours.[31, 32] CMS guidelines also state that plans should make marketing materials, such as promotional, enrollment, and benefit materials, available in any language that is the primary language of more than 10 percent of a plan's service area.[33] In 2009, CMS began making LEP population information available for plans when a particular LEP population exceeded the 10-percent threshold.[34] Finally, CMS guidelines state that plans must disclose on all required explanatory marketing materials that the document is available in alternative languages.[35]

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[29] OMH, *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations*. Accessed at http://www.thinkculturalhealth.org on February 1, 2010.

[30] CMS, Medicare Manual, Pub. 100-16, ch. 3, interpreting 42 CFR §§ 422.2264(e), 423.2264(e), and 423.128(d)(1).

[31] Ibid., § 30.7.

[32] Ibid., § 80.1.

[33] Ibid., § 30.7.

[34] CMS, *New Marketing Material Language Lookup Functionality in HPMS,* September 28, 2009. Accessed at http://www.cms.hhs.gov on March 1, 2010.

[35] CMS allows an exception to this disclosure for identification cards. CMS, *Medicare Managed Care Manual*, Pub. 100-16, ch. 3, § 50.5.8.

In 2008, CMS informed plans of concerns that ineffective processes may have been preventing LEP persons from receiving the language access services covered by CMS's marketing guidelines.[36] CMS distributed a memorandum to all plans listing best practices that plans could implement to better serve LEP persons. For example, CMS recommended that if plans use an interactive voice response system, they should ensure that callers who do not choose an option by pressing a number or speaking a word will automatically be connected with a person who can access interpretation services. In this memorandum, CMS cited OCR guidance as a useful tool for developing language access services for LEP persons.[37]

METHODOLOGY

To conduct this review, we collected information through a survey of randomly selected plans operating in 2009 in counties with a high percentage of LEP persons. OCR, OMH, and CMS staff provided additional context through structured interviews.

Scope

The MIPPA mandates that OIG report on plans' and providers' compliance with OCR guidance and CLAS standards. However, because CLAS standards are not mandatory, HHS lacks authority to enforce them. Therefore, we assessed plans' voluntary compliance as indicated by the extent to which they conducted the four-factor assessment recommended by OCR guidance and offered language access services consistent with CLAS standards. This study focused on CLAS standards 4–7, which OMH designated as the Language Access Services standards.

This study focused on plans that were located in counties with a high percentage of LEP persons to increase the likelihood that sampled plans needed to offer language access services. Medicare providers are covered in a companion report.

Finally, we broadened the definition of costs and savings to include nonfinancial obstacles and benefits.

[36] CMS, *Best practices for addressing the needs of non-English speaking and limited English proficient (LEP) beneficiaries,* January 2, 2008. Accessed at http://www.cms.hhs.gov on February 17, 2010.

[37] Ibid.

Sample

Plan sampling frame. We created a sampling frame of plans operating in counties with a high percentage of LEP persons. To do this, we used 2000 decennial Census data and 2009 enrollment data from CMS.[38] First, we used the Census data to rank counties by the percentage of residents who answered anything other than "very well" when asked how well they speak English. We selected the 10 percent of counties with the highest percentage of these LEP persons. Together, the 313 selected counties, representing 37 States, contained 72 percent of LEP persons residing in the United States. These LEP persons represented between 9 percent and 51 percent of all residents in each of the selected counties. Then, we used the CMS enrollment data to identify the plans offered in the selected counties. We identified 5,611 plans in the sampling frame.

Sample selection. After creating the sampling frame of 5,611 plans, we selected a simple random sample of 145 plans.[39] After selecting the sample, we excluded five plans because of ongoing OIG investigations and one additional plan because we discovered that it did not operate in 2009. The final sample consisted of 139 plans.

Data Collection

Survey. We emailed the survey to the sample of 139 plans in December 2009. We made three followup attempts by telephone. Data collection lasted through January 2010. Of the 139 plans, 135 responded to the survey, for an overall response rate of 97 percent. However, plans did not always answer every question; therefore, item response rates may be lower. No item response rate was less than 88 percent.

In the cases in which a health care organization operated multiple plans in the sample and offered the same language access services, we allowed the health care organization to submit one survey for all of its plans. Then, we recorded the responses individually for each associated plan. Twenty-four health care organizations, representing 107 of the sampled

[38] The U.S. Census Bureau's 2000 decennial Census has the most recent data on all counties for the same year.

[39] This sample design enabled us to estimate the percentage of plans with certain characteristics with +/- 10-percent precision at the 95-percent confidence level assuming a 75-percent response rate and assuming that 7 percent would be excluded because of ongoing OIG investigations.

plans, submitted surveys in this manner. An additional 28 plans responded individually.

Structured interviews. In January 2010, we conducted separate structured interviews with OCR and OMH staff to obtain background information. We interviewed OCR staff about their role and activities related to Title VI enforcement, OCR guidance, and the types of technical assistance OCR provided for language access services. We interviewed OMH staff about their activities related to CLAS standards.

In addition, to obtain background information about CMS's guidelines for plans related to the provision of language access services, we interviewed CMS staff. We interviewed CMS staff in January 2010.

Data Analysis

To analyze plans' survey responses, we calculated response category frequencies for the key questions related to whether plans conducted the four-factor assessment recommended by OCR guidance and whether plans offered language access services consistent with all four CLAS standards on language access services. We also analyzed the percentage of plans that completed each individual factor of the four-factor assessment and offered language access services consistent with each of the four CLAS standards.

We considered a plan to have conducted the four-factor assessment if the plan indicated at least one activity corresponding to each of the four factors. Table 1 lists each of the four factors and the corresponding survey question. See Appendix C for the categories of responses to each question.

Table 1: OCR Four Factors and Corresponding Survey Questions

Four Factors in OCR Guidance	Corresponding Question in Survey of Plans
Factor 1: The number or proportion of LEP persons eligible to be served or likely to be encountered in the recipient's service population	Which of the following sources of information does your plan use to determine the number or proportion of LEP persons from each language group represented in its geographic service area?
Factor 2: The frequency with which LEP persons come in contact with the recipient	Which of the following sources of information does your plan use to track how often it encounters LEP persons?
Factor 3: The importance, nature, and urgency of the program, activity, or service to people's lives	When determining whether to communicate to LEP persons in their preferred language, does your plan consider the importance and urgency of the activity, program, or service to people's lives?
Factor 4: The resources available to the recipient and costs for offering language access services	How does your plan assess whether it has resources available to provide language access services?

Source: OCR guidance and OIG survey of plans, 2010.

Similarly, we considered a plan to have offered language access services consistent with CLAS standards if it indicated activities meeting each of the four standards. For Standards 4, 6, and 7, we considered a plan to have offered language access services consistent with the standards if it indicated at least one activity corresponding to the standards. For Standard 5, plans needed to indicate at least two activities—one associated with verbal notification of rights and another associated with written notification. Table 2 lists the four CLAS standards on language access services and the corresponding survey question. See Appendix C for the categories of responses to each question.

Table 2: CLAS Standards and Corresponding Survey Questions

CLAS Standards on Language Access Services	Corresponding Question in Survey of Plans
Standard 4: Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.	During what percentage of your plan's business hours are language access services offered?
Standard 5: Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.	Does your plan inform LEP persons of their right to receive language access services in their preferred language in any of the following ways?
Standard 6: Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).	Which of the following training topics does your organization require for staff and contractors?
Standard 7: Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.	Which of the following written materials are translated into the languages of commonly encountered groups?

Source: CLAS standards and OIG survey of plans, 2010.

We did not ask plans about posting signs in languages of the commonly encountered groups for Standard 7, as we determined that signs were not applicable to plans.

We used the results of the response category frequencies for the CLAS standards to determine whether any standards were completed more or less frequently than any other standard. We used the Bonferroni method of multiple comparisons to determine whether any noted differences were statistically significant. A difference was statistically significant if the confidence interval of the difference did not contain zero using an alpha of 0.01.

Where possible, we calculated frequencies and ranges on the key questions related to costs, savings, nonfinancial obstacles, and benefits. We also reviewed plans' comments about how they calculated cost data to determine the extent to which reported costs were comparable.

Unless noted, we projected survey statistics to all 5,611 plans operating in the 313 counties with a high percentage of LEP persons. See

Appendix D for a list of 95-percent confidence intervals for all statistical projections.

Data Limitations

This report relies on self-reported data. We did not verify plans' responses.

Because populations may shift, the 2000 decennial Census data may not exactly reflect the counties with the highest percentage of LEP persons in 2009, when the sample was selected. However, they were the most recent data available for all counties in the same year.

Standards

This study was conducted in accordance with the *Quality Standards for Inspections* approved by the Council of the Inspectors General on Integrity and Efficiency.

Eighty-eight percent of plans conducted the four-factor assessment recommended by OCR guidance when determining what language access services to offer

Eighty-eight percent of plans in counties with a high percentage of LEP persons considered all four factors of the recommended assessment. The remaining 12 percent of plans considered three of the four factors. As noted previously, OCR guidance is not mandatory. Rather, it is guidance that plans may use to ensure meaningful access for LEP persons to critical services.

Table 3 lists the four factors and the percentage of plans that reported considering each factor.

Table 3: OCR Four Factors and Percentage of Plans Considering Each Factor

Four Factors in OCR Guidance	Percentage of Plans
Factor 1: The number or proportion of LEP persons eligible to be served or likely to be encountered in the recipient's service population	94%
Factor 2: The frequency with which LEP persons come in contact with the recipient	99%
Factor 3: The importance, nature, and urgency of the program, activity, or service to people's lives	96%
Factor 4: The resources available to the recipient and costs for offering language access services	100%

Source: OCR guidance and OIG analysis of plan survey responses, 2010.

Ninety-four percent of plans reported determining the number or proportion of LEP persons in their service areas

Corresponding to the first factor in OCR guidance, 94 percent of plans reported determining the number or proportion of LEP persons represented in their geographic service areas. The greater the number or proportion of LEP persons, the greater the likelihood that language access services are needed.

Plans determined the number or proportion of LEP persons represented in their geographic service areas primarily from two sources. Eighty-one percent of plans reported that they used Census data and 64 percent reported that they collected data from plan members.

Ninety-nine percent of plans reported determining the frequency of contact with LEP persons

Corresponding to the second factor in OCR guidance, 99 percent of plans reported determining the frequency with which they encountered LEP persons. The more frequent the contact with a particular language group, the more likely that language access services in that language are needed.

Plans reported collecting data on encounters with LEP persons primarily from two sources. Seventy-nine percent of plans reported using data collected from their call centers and 66 percent reported using data collected from plan member databases. Forty-nine percent of plans reported that they used both sources.

Ninety-six percent of plans reported considering the situation when determining what language access services to provide or reported offering services in all situations

Ninety-six percent of plans reported activities that correspond to the third factor in OCR guidance for determining the importance of language access services. This factor recommends that plans determine whether denial or delay of services or information because of a lack of language access services could have serious implications for LEP persons. To that end, 18 percent of plans reported assessing the importance and urgency of their programs, activities, and services. An additional 78 percent reported offering language access services in all types of situations regardless of importance and urgency, in which case determining the importance and urgency is no longer necessary.

All plans reported assessing the available resources

Corresponding to the fourth factor in OCR guidance, all plans reported assessing available financial, material, and staff resources when determining what language access services to offer. Plans may use information about available resources to help them balance costs and benefits when deciding what language access services to offer. Specifically, 94 percent of plans reported assessing the availability of bilingual staff, 79 percent reported assessing the availability of technology for providing language access services, and 47 percent reported assessing the financial resources available to them.[40]

[40] Choices are not mutually exclusive.

Sixty-seven percent of plans offered services consistent with all four CLAS standards on language access services

All plans operating in counties with a high percentage of LEP persons reported offering some language access services by either translating documents or providing interpreter services. However, only 67 percent offered language access services consistent with all four of OMH's CLAS standards on language access services. As noted previously, CLAS standards are not mandatory. Rather, they are a resource that plans can use when developing their language access services.

In addition to offering language access services directly, 79 percent of plans reported offering language access services or financial assistance to their contracted providers. Further, 48 percent of plans reported requiring their contracted providers to offer language access services to their patients. See Table E-1 in Appendix E for a list of the assistance that plans reported offering to their contracted providers.

Plans were least likely to offer language access services consistent with CLAS Standard 5, which recommends that patients be informed of their rights both verbally and in writing.[41] See Table 4 for the four CLAS standards on language access services and the percentage of plans that reported offering services consistent with each standard.

[41] The difference is statistically different from other standards at the 95-percent confidence level in a multiple comparison test using a Bonferroni threshold of 0.01.

Table 4: CLAS Standards and Percentage of Plans Offering Services Consistent With Each Standard

CLAS Standards on Language Access Services	Percentage of Plans
Standard 4: Provide language assistance services at no cost to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation.	94%
Standard 5: Provide to patients in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.	71%
Standard 6: Assure the competence of language assistance provided. Family and friends should not be used to provide interpretation services (except on request by the patient).	99%
Standard 7: Make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups represented in the service area.	94%

Source: CLAS standards and OIG analysis of plan survey responses, 2010.

Ninety-four percent of plans reported offering language access services during all business hours

Consistent with CLAS Standard 4, 94 percent of plans reported offering some type of language access services during all hours of operation. The 6 percent of plans that did not offer language access services during all hours of operation reported offering language access services during more than half of their business hours.

However, there is evidence that beneficiaries have difficulty accessing the language access services that plans provide through call centers. For example, one study found that only 69 percent of LEP persons calling plans could reach someone who spoke their primary language and were often unable to access translated documents from the plans.[42] This indicates that while plans may have language access services available, they may not be providing these services to all of the beneficiaries who need them.

[42] National Senior Citizen Law Center, *"Please Hold" Medicare plans leave limited English proficient beneficiaries waiting for access,* December 2008. Accessed at http://www.nsclc.org on February 17, 2010.

Seventy-one percent of plans reported informing LEP persons both verbally and in writing of their right to receive language access services

Consistent with CLAS Standard 5, 71 percent of plans reported informing LEP persons verbally and in writing of their right to receive language access services. Plans reported informing beneficiaries of language access services mostly in writing during the enrollment process. Specifically, 96 percent of plans reported informing LEP persons through enrollment materials or plan benefit materials, and 86 percent reported informing LEP persons through other marketing materials. However, only 71 percent of plans reported verbally informing LEP persons during the enrollment process.[43] In addition, the enrollment process typically occurs annually, which means LEP persons may not be informed of their right to receive language access services at each encounter with plans.

Ninety-nine percent of plans reported requiring training for staff and contractors on language access services

Consistent with CLAS Standard 6, 99 percent of plans reported requiring training for staff and contractors on language access services. Specifically, 96 percent of plans reported requiring training for staff or contractors on responding to LEP persons, 90 percent on language access policies and procedures, 73 percent on cultural competency, and 56 percent on language skills.[44]

Although most plans reported requiring training for staff and contractors about language access services, only 57 percent reported formally testing them on their skills and competencies in providing language access services. CLAS Standard 6 mentions formal testing as a way to assure the competence of language assistance provided by staff. Only 41 percent of plans reported either testing staff or contractors on their ability to interpret effectively or testing them on their language proficiency. See Table 5 for a list of the topics plans reported covering on formal tests.

[43] Choices are not mutually exclusive.

[44] Choices are not mutually exclusive.

Table 5: Testing Topics for Staff and Contractors

Testing Topics*	Percentage of Plans
Confidentiality requirements	57%
Plan's policies and procedures	55%
Medical terminology	42%
Ability to interpret effectively	41%
Proficiency in English and non-English languages	41%
*Choices are not mutually exclusive.	

Source: OIG analysis of plan survey responses, 2010.

Ninety-four percent of plans reported translating materials into the languages of commonly encountered groups

Consistent with CLAS Standard 7, 94 percent of plans reported translating written materials into the languages of commonly encountered groups. Plans reported translating a variety of materials. Eighty-seven percent of plans reported translating enrollment applications, 83 percent reported translating marketing materials, and 78 percent reported translating plan benefit materials.[45]

Only 49 percent of plans reported benefits to providing language access services and 57 percent reported obstacles

Although all plans reported offering some language access services, only 49 percent reported that providing language access services resulted in any benefits. The two most frequently reported benefits were related to communication.[46] Specifically, 46 percent of plans reported improvements in communication with beneficiaries and 10 percent reported improvements in communication between providers and their patients.

Only 1 percent of plans reported saving money by offering language access services. Twenty-eight percent of plans reported that they did not save money by providing language access services and 70 percent reported that they did not know whether they saved money.[47]

[45] Choices are not mutually exclusive.

[46] Choices are not mutually exclusive.

[47] Percentages do not add to 100 percent because of rounding.

Fifty-seven percent of plans reported obstacles to providing language access services

Fifty-seven percent of plans reported obstacles to providing language access services, including the costs of providing language access services, difficulties in identifying LEP persons, and a lack of staffing. See Table 6 for a list of obstacles that plans reported.

Table 6: Obstacles Reported by Plans

Obstacles*	Percentage of Plans
Costs	41%
Lack of means for staff to identify LEP persons	22%
Lack of staffing	20%
Broad range of languages spoken in the community	19%
Staff discomfort in providing language services	19%
Lack of training resources for staff	11%
Liability concerns	10%
*Choices are not mutually exclusive.	

Source: OIG analysis of plan survey responses, 2010.

The cost of providing language access services was the most frequently reported obstacle, cited by 41 percent of plans. In addition, 30 percent of plans reporting obstacles reported costs as the only obstacle. As previously noted, plans may include the costs of providing language access services in their administrative expenses that are subsidized by CMS.

A majority of plans indicated that they would like help in overcoming obstacles to providing language access services. In fact, 52 percent of plans reported that it would be useful to have additional assistance in implementing these services. In responding to the survey, these plans suggested specific areas for assistance. There were three general requests: that HHS (1) translate model documents to ensure the accuracy of documents and reduce costs for plans; (2) offer staff training and testing assistance, which would include providing materials and covering plan responsibilities, information on the LEP populations, and best practices; and (3) provide financial assistance for language access services, for both training staff and direct interpretation and translation services.

Although 79 percent of plans reported data on the costs of providing language access services, these data were not comparable

Of the 135 plans that responded to the survey, 106 reported data on the costs of providing language access services. For example, a small regional plan reported $407 in language access services expenditures in FY 2008, at $0.29 per LEP enrollee. On the other hand, a large national plan reported $3.7 million in language access services expenditures in FY 2008, at $52.78 per LEP enrollee.

Plans' comments about how they calculated cost data indicated that the wide range of costs might be the result of different approaches to calculating costs, rather than a reflection of varying levels of service. Some health care organizations that offer several plans indicated that they could report cost data only at the organizational level and not at the plan level. Others could report only on the total cost of a contract with a vendor and not the parts of the contract specific to language access services, and some plans could only estimate costs. Because of these differences in reporting, we were unable to make any determinations about costs of language access services.

RECOMMENDATION

Eighty-eight percent of plans in counties with a high percentage of LEP persons conducted the four-factor assessment recommended by OCR guidance when determining what language access services to offer. However, only 67 percent of plans offered services consistent with all four CLAS standards on language access services, largely because many did not inform LEP persons verbally of their right to language access services.

OMH created the CLAS standards to guide plans to become more responsive to the cultural and linguistic needs of diverse populations. Providing language access services is crucial to ensuring access to high-quality health care for LEP persons. Clear communication between LEP persons and plans can lead to better health outcomes for LEP persons.

The MIPPA requires OIG to make recommendations on improving compliance with and enforcement of CLAS standards. However, in keeping with our assessment of voluntary compliance, we make a recommendation to increase the percentage of plans that voluntarily offer services consistent with all four CLAS standards on language access services.

We recommend that:

OMH collaborate with CMS to inform plans that they should notify LEP persons both verbally and in writing of their right to receive language access services

More than one in four plans reported that they do not verbally inform LEP persons of their right to receive language access services. OMH should collaborate with CMS, as well as work with professional associations, to inform plans that they should notify LEP persons of their rights in writing and verbally. CMS has an established infrastructure for communicating with plans. OMH and CMS could use this infrastructure to encourage plans to inform LEP persons of their rights to language access services not only in writing during enrollment, but verbally every time LEP persons contact plans.

This joint effort could suggest ways in which plans could increase verbal notification of language access services at call centers. To help ensure that language access services are provided to those who need them, OMH and CMS could suggest that plans ensure that (1) call center staff are trained to identify LEP persons; (2) LEP persons are transferred from call centers to interpreter services; and (3) callers are automatically transferred to interpreter services in cases in which an

automated response is required and none is selected, as this may indicate that callers do not understand the automatic prompts.

AGENCIES' COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

OMH and CMS both concurred with our recommendation. OMH stated that it will work closely with CMS to inform plans that they should inform LEP persons both verbally and in writing of their rights to receive language access services. CMS reiterated its goal to provide clear, accurate, and timely information about language access services.

For the full text of the agencies' comments, see Appendix F.

APPENDIX ~ A

Section 187 of the Medicare Improvements for Patients and Providers Act of 2008

SEC. 187. OFFICE OF THE INSPECTOR GENERAL REPORT ON COMPLIANCE WITH AND ENFORCEMENT OF NATIONAL STANDARDS ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN MEDICARE.

(a) REPORT.–Not later than two years after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall prepare and publish a report on–

(1) the extent to which Medicare providers and plans are complying with the Office for Civil Rights' *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* and the Office of Minority Health's Culturally and Linguistically Appropriate Services Standards in health care; and

(2) a description of the costs associated with or savings related to the provision of language services. Such report shall include recommendations on improving compliance with CLAS Standards and recommendations on improving enforcement of CLAS Standards.

(b) IMPLEMENTATION.–Not later than one year after the date of publication of the report under subsection (a), the Department of Health and Human Services shall implement changes responsive to any deficiencies identified in the report.

APPENDIX ~ B

Culturally and Linguistically Appropriate Services in Health Care Standards[48]

Standard 1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

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[48] Office of Minority Health, *National Standards on Culturally and Linguistically Appropriate Services in Health Care (CLAS)*, March 2001. Accessed at http://minorityhealth.hhs.gov on February 12, 2010.

Standard 8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

APPENDIX ~ C

Categories of Responses to Key Survey Questions

Office for Civil Rights (OCR) Factor 1 Question: Which of the following sources of information does your plan use to determine the number or proportion of Limited English Proficient (LEP) persons from each language group represented in its geographic service area?

a) Census data
b) Collection of language data from plan members
c) Community assessment conducted by a community organization
d) Community assessment conducted by your organization
e) County or State health status reports
f) Medicare data
g) Other (please specify)

OCR Factor 2 Question: Which of the following sources of information does your plan use to track how often it encounters LEP persons?

a) Call center data
b) Claims records
c) Plan member database
d) Other (please specify)

OCR Factor 3 Question: When determining whether to communicate with LEP persons in their preferred language, does your plan consider the importance and urgency of the activity, program, or service to people's lives?

a) We provide language access services in all situations.
b) We consider the importance and urgency of the situation when determining what language access services to provide.

OCR Factor 4 Question: How does your organization assess whether it has resources available to provide language access services?

a) Assess availability of bilingual staff
b) Assess available technology
c) Determine whether outside funding is available
d) Examine operating funds to determine whether money is available
e) Review available community resources
f) Other (please specify)

Culturally and Linguistically Appropriate Services in Health Care (CLAS) Standard 4 Question: During what percentage of your plan's business hours are language access services offered?

a) All (100%)
b) More than 50% but less than 100%
c) Less than or equal to 50%
d) Plan does not offer language access services

CLAS Standard 5 Question: Does your organization inform LEP persons of their right to receive language access services in their preferred language in any of the following ways?

a) Given copies of language access rights materials in their preferred language
b) In enrollment materials
c) In marketing materials
d) In plan benefit materials
e) Told verbally during application process
f) Other (please specify)

CLAS Standard 6 Question: Which of the following training topics does your plan require for staff and contractors?

a) Cultural competence
b) Demographic data of communities served
c) How to collect data on primary language from LEP persons
d) How to respond to people who do not speak English
e) Information related to written policies and procedures regarding language access services
f) Language skills
g) Use of "I Speak" cards or other communication aids
h) Use of family members or friends as interpreters
i) Use of minor children as interpreters

CLAS Standard 7 Question: Which of the following written materials are translated into the languages of commonly encountered groups?

a) Application materials
b) Educational materials
c) Marketing materials
d) Notice of language access services
e) Plan benefit materials
f) Promotional materials
g) Wellness materials
h) Other (please specify)

APPENDIX ~ D

Estimates and Confidence Intervals

Table D-1: Estimates of Survey Responses

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of plans that conducted the four-factor assessment recommended by Office for Civil Rights (OCR) guidance when determining what language access services to offer	135	88.1	82.6%–93.7%
Percentage of plans that completed three of the four OCR factors	135	11.9	6.3%–17.4%
Percentage of plans that reported determining the number or proportion of Limited English Proficient (LEP) persons they are eligible to serve or likely to encounter in their geographic service areas (OCR Factor 1)	135	94.1	90.0%–98.1%
Percentage of plans that reported determining the frequency of contact with LEP persons (OCR Factor 2)	135	98.5	94.8%–99.8%
Percentage of plans that reported considering the situation when determining what language access services to provide or reported offering services in all situations (OCR Factor 3)	135	95.6	92.0%–99.1%
Percentage of plans that reported assessing the available resources for offering language access services (OCR Factor 4)	135	100.0	97.3%–100%*
Percentage of plans that reported they used Census data to determine the number or proportion of LEP persons represented in their geographic service areas	135	80.7	74.0%–87.5%
Percentage of plans that reported the collected data from plan members to determine the number or proportion of LEP persons represented in their geographic service areas	135	64.4	56.3%–72.6%
Percentage of plans that reported using data collected from call centers to determine the frequency of contact with LEP persons	135	78.5	71.5%–85.5%
Percentage of plans that reported using data collected from plan member databases to determine the frequency of contact with LEP persons	135	65.9	57.8%–74.0%
*Confidence interval calculated with an exact method based on the binomial distribution.			

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Table D-1: Estimates of Survey Responses, *continued*

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of plans that reported using data both from call centers and from plan member databases when determining the frequency of contact with LEP persons	135	48.9	40.3%–57.4%
Percentage of plans that reported assessing the importance of their program activities and services	135	17.8	11.2%–24.3%
Percentage of plans that reported offering language access services in all types of situations regardless of importance and urgency	135	77.8	70.7%–84.9%
Percentage of plans that reported assessing the availability of bilingual staff for providing language access services	135	94.1	90.0%–98.1%
Percentage of plans that reported assessing the availability of technology for providing language access services	135	78.5	71.5%–85.5%
Percentage of plans that reported assessing the financial resources available to them when determining whether to provide language access services	135	47.4	38.9%–55.9%
Percentage of plans that offered language access services consistent with the four selected Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards	135	66.7	58.6%–74.7%
Percentage of plans that reported offering some language access services	135	100.0	97.3%–100%*
Percentage of plans that reported offering language access services and financial assistance to providers	135	79.3	72.3%–86.2%
Percentage of plans that reported requiring providers to offer language services to their patients	135	48.1	39.6%–56.7%
Percentage of plans that reported offering language access services during all business hours (CLAS Standard 4)	135	94.1	90.0%–98.1%
Percentage of plans that reported informing LEP persons both verbally and in writing of their right to receive language access services (CLAS Standard 5)	135	71.1	63.4%–78.9%
*Confidence interval calculated with an exact method based on the binomial distribution.			

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Table D-1: Estimates of Survey Responses, *continued*

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of plans that reported requiring training for staff and contractors on language access services (CLAS Standard 6)	135	99.3	95.9%–99.9%*
Percentage of plans that reported translating materials in the languages of commonly encountered groups (CLAS Standard 7)	135	94.1	90.0%–98.1%
Percentage of plans that reported offering language access services during more than half of their business hours	135	5.9	1.9%–10.0%
Percentage of plans that reported informing LEP persons of their right to receive language access services in enrollment materials	135	96.3	93.1%–99.5%
Percentage of plans that reported informing LEP persons of their right to receive language access services in plan benefit materials	135	95.6	92.0%–99.1%
Percentage of plans that reported informing LEP persons of their right to receive language access services in other marketing materials	135	85.9	80.0%–91.9%
Percentage of plans that reported informing LEP persons of their right to receive language access services verbally during the enrollment process	135	71.1	63.4%–78.9%
Percentage of plans that reported training staff or contractors on responding to LEP persons	135	96.3	93.1%–99.5%
Percentage of plans that reported training staff or contractors on language access policies and procedures	135	89.6	84.4%–94.8%
Percentage of plans that reported training staff or contractors on cultural competency	135	72.6	65.0%–80.2%
Percentage of plans that reported training staff or contractors on language skills	135	55.6	47.1%–64.0%
Percentage of plans that reported formally testing the skills and competency of staff and contractors in providing language access services	135	57.0	48.6%–65.5%
Percentage of plans that reported testing staff and contractors on their ability to interpret effectively	135	41.5	33.1%–49.9%

*Confidence interval calculated with an exact method based on the binomial distribution.

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Table D-1: Estimates of Survey Responses, *continued*

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of plans that reported testing staff and contractors on their proficiency in English and non-English languages	135	40.7	32.3%–49.1%
Percentage of plans that reported testing staff and contractors on knowledge of confidentiality requirements	135	57.0	48.6%–65.5%
Percentage of plans that reported testing staff and contractors on knowledge of plans' policies and procedures	135	54.8	46.3%–63.3%
Percentage of plans that reported testing staff and contractors on knowledge of medical terminology	135	42.2	33.8%–50.7%
Percentage of plans that reported translating enrollment applications into the languages of commonly encountered groups	135	86.7	80.9%–92.5%
Percentage of plans that reported translating marketing materials	135	83.0	76.5%–89.4%
Percentage of plans that reported translating plan benefit materials	135	77.8	70.7%–84.9%
Percentage of plans that reported benefits to providing language access services	135	48.9	40.3%–57.4%
Percentage of plans that reported obstacles to providing language access services	123	56.9	48.0%–65.8%
Percentage of plans that reported improved communication with Medicare beneficiaries by offering language access services	135	45.9	37.4%–54.4%
Percentage of plans that reported improved communication between providers and their patients by offering language access services	135	10.4	5.2%–15.6%
Percentage of plans that reported saving money by providing language access services	135	1.5	0.18%–5.3%*
Percentage of plans that reported that they did not save money by providing language access services	135	28.1	20.5%–35.8%
Percentage of plans that reported that they did not know whether they saved money by providing language access services	135	69.6	61.8%–77.5%

*Confidence interval calculated with an exact method based on the binomial distribution.

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Table D-1: Estimates of Survey Responses, *continued*

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of plans that reported cost as an obstacle to providing language access services	123	41.5	32.6%–50.3%
Percentage of plans that reported a lack of means for staff to identify LEP persons as an obstacle	123	22.0	14.5%–29.4%
Percentage of plans that reported being understaffed as an obstacle	123	20.3	13.1%–27.5%
Percentage of plans that reported the broad range of languages spoken in the community as an obstacle	123	18.7	11.7%–25.7%
Percentage of plans that reported staff discomfort in providing language access services as an obstacle	123	18.7	11.7%–25.7%
Percentage of plans that reported a lack of training resources for staff as an obstacle	123	10.6	5.1%–16.1%
Percentage of plans that reported liability concerns as an obstacle	123	9.8	4.4%–15.1%
Percentage of plans that reported cost as their only obstacle	70	30.0	19.0%–41.0%
Percentage of plans that indicated that it would be useful to have additional assistance in implementing language access services	128	52.3	43.6%–61.1%
Percentage of plans that reported financial data on language access services	135	78.5	71.5%–85.5%

Source: Office of Inspector General analysis of plan survey responses, 2010.

APPENDIX ~ E

Supplemental Analysis Table

Table E-1: Assistance Plans Reported Offering to Providers

Ways Plans Reported Giving Assistance to Providers*	Sample Size	Percentage of Plans	95-Percent Confidence Interval
Provide access to interpreters	135	58.5	50.1%–66.9%
Provide education materials	135	45.2	36.7%–53.7%
Translate materials for distribution to patients	135	37.8	29.5%–46.1%
Train providers and their staffs on communicating with LEP persons	135	17.8	11.2%–24.3%
Provide financial assistance for language access services	135	8.9	4.0%–13.8%

*Choices are not mutually exclusive.

Source: Office of Inspector General analysis of plan survey responses, 2010.

APPENDIX ~ F

Agencies' Comments

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary
Office of Public Health and Science

Office of Minority Health
Washington, D.C. 20201

DATE: May 26, 2010

TO: Daniel R. Levinson
Inspector General

/S/

FROM: Garth N. Graham, M.D., M.P.H.
Deputy Assistant Secretary for Minority Health
Office of Minority Health
Office of the Secretary

SUBJECT: OIG Draft Reports: Guidance and Standards on Language Access Services: Medicare Plans, OEI-05-10-00051

Thank you for the opportunity to review and respond to the OIG draft report. We appreciate OIG's efforts to examine the extent Medicare Plans are fulfilling the requirements of (1) OCR's Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (OCR guidance) and (2) OMH's CLAS standards.

Based on our review of the report, our responses will only focus on those areas that apply to the CLAS Standards.

OIG Recommendation: Medicare Plans: OEI-05-10-00051

- **OMH should inform Medicare plans that they should notify LEP persons both verbally and in writing of their right to receive language access services.**

  OMH should collaborate with CMS, as well as work with professional associations, to inform Medicare plans that they should notify LEP persons of their rights in writing and verbally. CMS has an established infrastructure for communicating with Medicare plans. OMH and CMS could use this infrastructure to encourage Medicare plans to inform LEP persons of their rights to language access services not only in writing during enrollment, but verbally every time LEP persons contact Medicare plans.

  This joint effort could suggest ways in which Medicare plans could increase verbal notification of language access services at call centers. To help ensure that language access services are provided to those who need them, OMH and CMS could suggest that Medicare plans ensure that (1) call center staff are trained to identify LEP persons; (2) LEP persons are transferred from call centers to interpreter services; and (3) callers are automatically transferred to an interpreter service in cases in which an automated response is required and none is selected, as this may indicate that the caller does not understand the automatic prompts.

OMH concurs with OIG's recommendations. The OMH will work closely with CMS to implement the specific recommendations as outlined in the OIG draft report to inform LEP persons both verbally and in writing of their rights to receive language access services.

U.S. Public Health Service

APPENDIX - F

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Office of the Administrator
Washington, DC 20201

DATE: MAY 20 2010

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Acting Administrator and Chief Operating Officer

SUBJECT: Office of Inspector General (OIG) Draft Report: "Guidance and Standards on Language Access Services: Medicare Plans" (OEI-05-10-00051)

Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report entitled: "Guidance and Standards on Language Access Services: Medicare Plans" (OEI-05-10-00051)

In this draft correspondence, the OIG (1) determined the extent to which Medicare plans conducted the four factor assessment recommended by the Office for Civil Rights' (OCR) guidance when determining what language access services to offer; (2) determined the extent to which Medicare plans offered language access services consistent with the Office of Minority Health's (OMH) Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards on language access services; (3) determined the extent to which Medicare plans encountered benefits, including savings, and obstacles to providing language access services and (4) described costs associated with providing language access services.

It is our goal at the Centers for Medicare & Medicaid Services (CMS) to provide clear, accurate, and timely information regarding Title VI prohibition against National Origin Discrimination affecting Limited English Proficient persons. The CMS concurs with the recommendation stated in the report.

Thank you for the opportunity to review the report and provide feedback on this OIG report.

ACKNOWLEDGMENTS

This report was prepared under the direction of Ann Maxwell, Regional Inspector General for Evaluation and Inspections in the Chicago regional office, and Thomas F. Komaniecki, Deputy Regional Inspector General.

Mark Stiglitz served as the team leader for this study and Meghan Kearns served as the project lead. Other principal Office of Evaluation and Inspections staff from the Chicago regional office who contributed to the report include Melissa Baker, Benjamin Dieterich, Nicole Hrycyk, Ericka Kilburn, and Margarita Rodriguez; central office staff who contributed include Heather Barton and Kevin Farber.

Office of Inspector General

http://oig.hhs.gov

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.