FAQs: Health Equity Meaningful Language Access to Culturally Responsive Health Care Services - CCO Incentive Metric

Contents

FAQs: Meaningful Language Access to Culturally Responsive Health Care Services CCO Incentive Metric

This FAQ answers common questions about the CCO Quality Incentive Program's *Health Equity Measure: Meaningful Access to Health Care Services for persons with limited English proficiency and persons who are Deaf or Hard of Hearing*. Current technical specifications for the measure can be found here. This FAQ is primarily for providers and CCOs implementing data collection for the measure.

For the September 2024 update, several changes were made to the FAQ:

1. Brand new questions have "(Added 9/2024)" at the beginning of the initial question.
2. Questions regarding sample reporting and no longer existing technical requirements were removed since the incentive metric transitioned to full population in 2024.
3. Changed limited English proficiency (LEP) to prefers a language other than English (LOE). This terminology change does not reflect a change in metric specifications. The change is meant to better reflect a strength-based approach.
4. Updated legal references such as Oregon Administrative Rules (OARs) and links.
5. Substantive changes beyond those listed above have "(Updated 9/2024)" at the beginning of the initial question.

Increasing Meaningful Language Access

(Updated 9/2024) What is the intent of the measure?

The *Health Equity Measure: Meaningful Access to Health Care Services for Persons Who Prefer a Language Other than English (LOE) and Persons Who Are Deaf or Hard of Hearing* supports an individual's right to communicate with health care providers in the language they feel most comfortable using. To do this, it ensures that members who prefer a language other than English and members who are Deaf or hard of hearing receive meaningful access to culturally appropriate and high-quality language access services. The incentive measure, therefore, requires that either an OHA-qualified or -certified health care interpreter (HCI) or an in-language provider with a high level of proficiency in the member's preferred language deliver language access services.

The measure increases accountability for provider systems and CCOs to provide quality language access services through the collection of HCI and in-language utilization data. The specifications are not legal requirements for language access in the state of Oregon or federal law. Instead, the measure provides a foundation for quality improvement work regarding language access and fixing systemic inequities in the healthcare system.

How will the measure affect members' choices?

Patients deserve high-quality interpreters and in-language providers who effectively communicate complex medical information. Patients are still able to bring family and friends to an appointment, but this measure supports patients' access to high quality language services. The measure makes it less likely that appointments will be delayed if friends and family are not available to interpret for the member.

The incentive measure requires that policies are in place to provide high quality interpreter services at appointments and health care events when requested. The measure applies to physical, behavioral and dental health care services delivered in all settings including, but not limited to, hospitals, emergency departments, outpatient settings, home health, and telehealth.

(Updated 9/2024) Which laws require CCOs and providers to offer health care interpreter (HCI) services and other language access services?

Federal and state laws and policy require the use of health care interpreters (HCIs) in health care:

- Oregon law (ORS 413.552) provides information on health care interpreters and language access. Oregon Administrative Rules require onsite and telehealth health care interpreting be provided by OHA-qualified or -certified HCIs and in-language providers who have passed proficiency requirements. For more detail and exceptions, see OAR 950-050-0160.
- Language assistance that results in accurate, timely, and effective communication at no cost to LOE individuals. For LOE individuals, meaningful access denotes access that is not significantly restricted, delayed or inferior as compared to programs or activities provided to individuals who prefer English. (https://www.justice.gov/sites/default/files/open/legacy/2012/05/07/language-access-plan.pdf; Department of Justice, 2012)
- Title VI of the Civil Rights Act, The Americans with Disabilities Act and Amendments Act of 2008, and Section 1557 of the Affordable Care Act require any entity that receives federal funding, including Medicaid dollars, to provide meaningful access to limited English proficiency (LEP) persons and sign language interpretation for the deaf and hard of hearing persons, at no cost, during all healthcare encounters. The requirements apply to all providers regardless of size, including pharmacies, hospitals, primary care offices, occupational therapist, dentists, mental health providers, labs, and community-based organizations, among others.
- OAR 410-141-3515 and 950-050-0180 require CCOs to use OHA-qualified or -certified HCIs to assure the quality of spoken and sign language interpretation. OAR 950-050-0160 outlines similar requirements of providers, including what constitutes as a documented "good faith effort" to schedule with an HCI from the central registry in the case where an OHA-qualified or -certified health care interpreter is not available.
- The accreditation and state registry enrollment process for OHA-qualified and -certified HCIs provide convenient access to a state-recognized and locally available quality workforce on the HCI registry. OHA has dedicated significant efforts to the development of the health care interpreter workforce; however, available data indicate that this workforce has been underutilized.

Incentive Metrics and Reporting

(New 9/2024) Where would we find the latest MLA specifications?

The 2024 specifications are located here: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2024-specs-(Health-Equity-Meaningful-Access)-2023.06.17.pdf. All specifications can be found on the CCO Metrics website using the filter at the bottom of the page.

(New 9/2024) Where can I find more information on statewide and CCO level performance on the MLA metric and other measures from 2023?

We are happy to announce that the CCO Metrics 2023 Final Report has been published. This report is a summary of performance by Oregon's coordinated care organizations (CCOs) in 2023. It includes highlights of statewide performance and CCO payments for 2023 incentive metrics in the CCO Quality Incentive Program. This report is supplemented by the CCO Performance Metrics Dashboard, which will be updated with 2023 data later this fall. A list of all the CCO metrics program can be found here.

What parts of the measure are incentivized as part of the CCO Quality Incentive Program?

The measure has two components. The measure has two components that CCOs must meet as part of the CCO Quality Incentive Program. Component 1 gives CCOs credit for creating the infrastructure for high quality

communication and language access services and establishing data collection processes for measuring the language service quality in Component 2. Component 2 provides information on what percentage of health care visits by members with interpreter needs who receive high quality language access services. For each measurement year, the CCO Quality Incentive program publishes the technical specifications and benchmarks, improvement targets, and other requirements needed to pass the measure here.

For Component 1, each section of the CCOs self-assessment has a specific number of must-pass questions and minimum required points that increases with each measurement year. To meet the benchmark, the CCO must:

- answer all survey questions,
- pass the questions required for that measurement period, *and*
- meet the minimum points required for that measurement year.

For Component 2, the incentive measure rate calculation is the percentage of health care visits by members with interpreter needs who receive high quality language access services. This measure is:

$$\frac{\text{Number of visits with interpreter services provided by OHA-certified or qualified interpreters or in language provider who passed proficiency requirements in members' preferred language}}{\text{Number of visits for members with interpreter needs}}$$

(New 9/2024) What is the requirement for health care interpreters and language providers?

Currently, OAR 950-050-0160 is the requirement for health care interpreters and in language providers. As stated in the OAR, all providers must have documented proficiency and have adequate proficiency to ensure language proficiency is being met. The requirements in the CCO Quality Incentive Program Health Equity Measure: Meaningful Access to Health Care Services for persons with limited English proficiency and persons who are Deaf or Hard of Hearing – MY2024 (HEM) outline provider (i.e., clinician) proficiency requirements for those who want to receive numerator credit for the incentive measure if an OHA-qualified or -certified health care interpreter is not used.

The HEM measure is similar to the OAR in that it requires providers and CCOs to document the proof of proficiency. The measure, however, outlines what proficiency test and score is needed to receive credit for meeting Component 2. An exact score is not currently listed in the OAR for in language providers.

Component 1: CCO Language Access Self-Assessment Survey

(New 9/2024) Can OHA clarify how they define language triaging, and identify if there is a standard protocol or process for conducting language triaging that they would recommend CCOs reference?

For the purposes of the metric, language triaging refers to a telephonic system (also referred to as a "multilingual phone tree" or "multilingual integrated voice prompts") that allows for LOE callers to hear and respond to the automated options presented over the phone in language they feel most comfortable using. This service is typically delivered by contractors such as Language Line via their DirectResponse program.

We broadened the language to "language triaging" instead of "multilingual phone trees" to be inclusive of clinics that may not have the resources to implement an automated system but can still develop a workflow for how to communicate effectively with potential LOE patients who call in to make an appointment. One example of a workflow clinics may implement includes providing a simple script to scheduling and front desk staff to inform callers of language access services available to LOE patients.

There is no standard process for conducting language triaging, but OHA staff are available to problem-solve how your CCO can develop a process for providing language access services to members at the time of calling in to schedule an appointment.

(New 9/2024) What is the intent of the Component 1 question, "Does your CCO inform LOE and Deaf and hard of hearing members about resources they can use to schedule an appointment with a provider"?

The intent of this question is to assess whether CCOs are providing ample notice of language access services and resources to LOE and Deaf and hard of hearing members, especially when scheduling an appointment over the phone (by calling the clinic) or online (on CCO or clinic websites). Examples of this could include dissemination of translated materials with notice of navigator resources and step by step instructions for LOE members to schedule an appointment online in their preferred language.

Component 2: Percent of Visits with Interpreter Needs where Language Access Services were Provided

(New 9/2024) Will the Quarterly Interpreter Services Report be used to calculate performance on the Health Equity Measure for Measure Year 2024 and beyond?

Yes, starting in 2024, the CCO quality measure shifted to full-population results, which align with the quarterly contract reports and sync on the full year period for the April submissions. MY2023 was the last year for the incentive measure to use the hybrid method where OHA sample some visits and put in a different template for the CCOs to fill out.

(Updated 9/2024) How can we get the most recent registry of OHA-qualified or -certified health care interpreters to calculate the incentive metric for Component 2?

OHA provides full updates of the OHA HCI Registry on a monthly basis in csv format. If you would like to receive the list on a monthly basis, please email Metrics Questions at Metrics.Questions@odhsoha.oregon.gov.

The HCI Registry Website list focuses on operational needs by allowing CCOs access to interpreters who may be available to assist members. The public can download the full HCI registry by clicking "Search" and then clicking the "Download a Spreadsheet" button underneath the "Search Results" heading.

(Updated 9/2024) How can I verify that an interpreter is OHA-qualified or -certified?

All OHA-qualified or -certified Health Care Interpreters (HCIs) have a unique numeric registry number up to six digits and a badge that identifies the credential. OHA also maintains HCI Registry Website list where individuals can look up interpreter's registry number.

We recommend that you require OHA-qualified or -certified health care interpreters to provide their registry number on their invoices for payment. Doing so will also help ensure that contractors work with OHA-qualified or -certified health care interpreters and that this information is readily available to your CCO or clinic for reporting to OHA.

(New 9/2024) The OHA-qualified and -certified HCI registry identifier sometimes shows up as alphanumeric (i.e., HCI0000) and in the template it is a five- to six-digit number. Can you clarify which one should be used for reporting?

OHA prefers that CCOs clean the data to get the 5- to 6-digit numbers and submit the 5- to 6-digit numbers when reporting visits for members with language access needs.

If we use remote HCIs through a third-party service vendor, does that count toward the incentive measure numerator?

Yes, remote interpretation is allowed by the metric if the interpreters are OHA-qualified or -certified. To ensure that services provided by remote interpreters are counted as part of the numerator, CCOs and providers must proactively setup workflow processes to ascertain whether interpreters are OHA-qualified or -certified.

(Updated 9/2024) What happens when a member's family member or friend provides interpreter services and the member doesn't have an interpreter present?

Unless the patient's family member or friend is an OHA-qualified or -certified interpreter, the visit will not be counted as a numerator hit. Having a family member or friend providing interpreter services is discouraged at all times, unless there is verifiable documentation of patients' preferences. Also, such services do not qualify for denominator exclusion unless 1) the member refused because the in-language visit is provided by a provider who is not an OHA-qualified or certified HCI nor has passed proficiency requirements in the member's preferred language and/or 2) the member confirms that the interpreter flag is inaccurate. Starting in 2025, an additional exclusion will be available for members who do not need interpreter services for the visit.

(New 9/2024) As a CCO, I receive the monthly qualified and certified HCI registry list. How should this list be used internally by CCOs and providers we send this list to?

The monthly HCI registry list, sent via the CCO TAG list serv, is intended for validation of the HCI numbers submitted by providers for the CCO incentive metric. The list does not contain the interpreters' contact information or scheduling availabilities. The monthly HCI registry list includes all qualified and certified HCIs who are active including those HCIs who do not wish to be contacted as well as inactive HCIs. Expired HCI registry numbers will still count for the purposes of the metric; however, we encourage you to use those with current credentials in alignment with OAR 950-050-0160 and 950-050-0180.

The HCI Registry Website list focuses on operational needs by allowing CCOs access to interpreters who may be available to assist members currently. CCOs and providers can search by name, language, or certain counties, or they can download the full HCI registry by clicking "Search" and then clicking the "Download a Spreadsheet" button underneath the "Search Results" heading. The list contains:

- The interpreter's HCI number, name, contact information (phone number, email), service language, service areas, scheduling availability, etc.
- Only interpreters whose credentials (OHA certification/qualification) are current.
- Only those interpreters who want to be publicly searchable for scheduling.

(New 9/2024) Do HCI credentials that are expired count towards the metric?

The measure specifications currently don't require the interpreter to have an 'active' OHA-qualified or -certified status at the time of the service nor at the time of data collection or reporting. For example, in the 2023 calculation, we gave credits to all valid HCI numbers ever assigned as of April 15, 2024 (the full extract was provided in the initial review feedback data).

(New 9/2024) How should CCOs document provider proficiency for the purposes of the metric? Do CCOs need to document the test score?

CCOs will need to verifiably document how a provider meets proficiency requirements. After completing the test, the provider would receive a certificate of completion with a score. This document should be sent to CCOs to confirm that the provider qualifies as passing the proficiency test in the member's preferred language. CCOs must have native speaker documentation equivalent to tracking proficiency tests (e.g., a diploma). OHA recommends verifying language proficiency during the verification of the clinician's credentialing process or connect with your credentialing team.

How should in-language provider visits be tracked in the language access reporting template? Can you provide scenarios on how to report in language provider who has 1) passed the proficiency requirements, 2) has not passed the proficiency requirements, and 3) in language provider who has not passed proficiency requirements and has a certified or qualified HCI present?

OHA maximizes the calculation to give credit when the visit meets the numerator parameters (i.e., in-language provider who passed the proficiency test or worked with an OHA-qualified or -certified HCI). Numerator credit is only given once per visit. At the July CCO TAG meeting, OHA staff presented on how to report each of the scenarios in the template. Please see the presentation starting at 23:00 and the slides starting at 15.

(New 9/2024) Should we report when a visit for someone who has interpreter needs is cancelled?

If a visit never occurred, regardless of whether it was a cancellation or a patient no-show, it should not be reported.

(New 9/2024) What is the best way to report long inpatient stays with multiple providers?

Currently, the specifications call for reporting as one visit for a unique inpatient stay. The CCO can combining all claims during the entire inpatient stay into one reported event and report one "maximum qualification" of any language access services provided throughout the entire stay. However, you can also choose to report the professional services/visit as separate events during the stay (in addition to the single inpatient event) and get separate numerator credits for language services provided at separate visits.

Please be aware that reporting for the metric and legal requirements around language access services differ. Healthcare providers are obligated to provide language access services for all communication during an inpatient stay. This reporting requirement should not be seen as the requirement for inpatient language access services.

(New 9/2024) At what age are pediatric patients (those under 18 years of age) able to refuse interpreters for themselves?

In Oregon, the age of medical consent is 15 years of age at which a pediatric patient can refuse an interpreter service for themselves. But separate from the MLA requirement, the best practice is to verifiably document such refusals.

(New 9/2024) Should CCOs include deceased members in our MLA data report? If they are excluded, would they be excluded from the measurement year?

Deceased members can be excluded. The deceased members' visits would be excluded from the full measurement year.

(New 9/2024) Should CCOs exclude dialysis visits?

Dialysis visits are included in the measure since dialysis involves patient interaction and are not classified as an ancillary service in the Oregon Health Grouper (see Appendix 4 of technical specifications for MY2024). Dialysis is mapped to the M-60 classification. If there is documentation for member refused language services for reasons qualified for denominator exclusion, the visit still needs to be reported, but can be excluded from the denominator when calculating the language services access rates.

(New 9/2024) What coverage codes (e.g., for CCOs) are intended to be included in Quarterly Interpreter Service Reports and Annual Hybrid Submission?

The HEM is inclusive of all CCO coverage types, eligibility categories and does not have any continuous enrollment requirements. All CCO members with interpreter needs and have any qualifying visits in the year should be included in the Component 2 reports. The CCO can include additional members in full population reports in the quarterly contract reporting which will be used for the incentive metric starting in 2024. If a member who the CCO has identified as having language access needs is included in reporting, all visits for the member must be included. OHA requires the CCO to report all members in the eligible population, including Healthier Oregon Program (HOP) and Basic Health Plan (BHP) members. However, due to the incentive program limitation with federal funds, HOP and BHP member results are excluded from the quality rate to be used for incentive funds determination.

Becoming an OHA-qualified or -certified health care interpreter (HCI)

How can I become an OHA-qualified or certified HCI?

Details on how to complete the OHA credentialing process, including language proficiency testing and training, can be found on OHA's Equity and Inclusion Division website.

What are the requirements to become an OHA-qualified or -certified HCI?

To become qualified or certified, an HCI must complete an OHA-approved 60-hour training, fulfill language proficiency requirements in both English and the target language, and submit a complete application package. Detailed requirements are here. OHA has worked to reduce barriers to being included in the HCI Central Registry by waiving the $25 application fee and no longer requiring a background check.

(Updated 9/2024) Where can I find information on how to sign up for OHA-approved health care interpreter training programs?

The OHA-approved HCI training programs are published on OHA's Equity and Inclusion Division website. Most of the approved training programs offer online courses and provide flexible scheduling options for completing required training modules. The 60 hours of HCI training requirements are listed in OAR 950-050-0060. The curriculum includes 52 hours of integrated medical terminology; anatomy and physiology; introductory health care interpreting concepts and modes, including supervised practice; and eight hours of Health Care Interpreting.

(New 9/2024) Where can I find a list of OHA-approved language vendors?

Please see under language proficiency testing vendor application for details:
https://www.oregon.gov/oha/EI/Pages/HCI-training.aspx

(New 9/2024) Will OHA accept ALTA proficiency tests?

OHA has added ALTA to the list of approved proficiency tests. A score of 8 or above is required for both in-language providers and qualified or certified HCIs. This score is equivalent to an 'advanced mid' rating or above on the ACTFL scale.

In-Language Providers

Which clinical staff qualify as an in-language provider visit versus clinical staff providing interpreter services during the visit?

An in-language provider visit means that the main performing provider (i.e., rendering provider) delivering the services for the visit is proficient (i.e., passed a language proficiency assessment or meets the native speaker requirement) in the member's preferred language. The communication between the provider and the patient is direct without the need of any interpreter. If the provider delivering the services meets the proficiency requirements, this visit counts as a numerator hit for the measure. If the provider delivering the services has not passed the proficiency requirements for a numerator hit, it does not count towards the incentive measure. This type of in language visit can be excluded if there is documented evidence that the member was offered but the member:

- Refused free of charge interpreter services,
- Attested that they were satisfied with the direct communication for this type of in language visit, and
- Refused any type of interpreter services including the help of a different clinic staff.

This type of visit could be documented as Member Refusal Reason "1" in the language access reporting template and the visit can be excluded from the metric.

If a different supporting clinic staff other than the provider delivering services (such as a supporting registered nurse or medical assistant) helped interpret between the patient and the rendering provider, the visit should be counted as "bilingual staff interpreter service". The visit would **not** be an in-language provider visit and would not qualify for a denominator exclusion. Using a clinic staff interpreter is a form of interpreter service and staff who interpret during the visit need to become an OHA-qualified or -certified HCI to count as a numerator hit for the metric.

(New 9/2024) Can you provide examples of main performing (rendering) providers that are eligible to be in-language providers?

OHA did an analysis of visits for members with who prefer a language other than English. These are the top 10 main performing (rendering) provider types listed from most common to least common:

1. Physician and Physician Assistants
2. Dentist
3. Nurse Practitioner
4. Behavioral Health Counselor
5. Optometrist
6. Physical Therapist
7. Dental Hygienist
8. Chiropractor
9. Clinical Social Worker
10. Midwife

Other provider types also exist for main performing providers. Gaps in access to certain provider types may exist because interpreter services are not readily available or an in-language provider does not exist. Recently the

Healthier Oregon Program evaluation report found that members who prefer a language other than English had difficulty accessing specialists.

(New 9/2024) Would someone who is a Certified Nursing Assistant count as an in-language provider?

Certified Nursing Assistants (CNA) do not count as an in-language provider for the purposes of the metric. If the CNA is an OHA-qualified or -certified HCI, the visit would count towards the numerator.

(New 9/2024) Do native speakers who are the primary performing providers count towards the metric?

Starting in MY2024, primary performing providers who have a degree in high school or above in a country where instruction is primarily in the non-English language and are a native speaker of the non-English language count towards the numerator for component 2 incentive metric. These providers do not need to take a proficiency test for the purposes of the metric, but organizations may still choose to require proficiency tests for all in language providers. The native speaker change was made retroactively mid-year in 2024 to accommodate feedback from CCOs. CCOs must have native speaker documentation equivalent to tracking proficiency tests for these providers (e.g., a diploma).

(New 9/2024) What proficiency tests count for in-language provider numerator credit for Component 2?

For MY2024, OHA requires that the language proficiency test be a valid, commonly recognized test in the language certification field. To pass the proficiency test, the provider must pass the proficiency test with a score of:

- 2+* or higher for Language Line Solutions' (LLS) proficiency test or a score of 'Competent' on LLS Bilingual Fluency Assessment (BFA) or LLS Bilingual Fluency Assessment for Clinicians (BFAC)
- Advanced-mid level or higher for American Council on the Teaching of Foreign Language (ACTFL) (i.e., Language Testing International's proficiency test)
- ALTA proficiency tests at 8 or above
- In-language providers that have passed an OHA-approved Oral Proficiency Interview (OPI) also qualify for passing the language proficiency requirement.

The BFA and BFAC have recently been added. Please note that in 2025, LLS increases to 3+ to stay in alignment with the HCI registry. Providers who have a degree in high school or above in a country where instruction is primarily in the non-English language and the in-language provider is a native speaker of the non-English language.

(New 9/2024) Is OHA going to expand the approved language proficiency test options for in language providers? Or establish a process for getting additional language proficiency tests added to the approved list?

The proficiency testing requirements for in-language providers are intentionally aligned with the proficiency testing requirements for OHA-qualified HCIs. The process for getting additional language proficiency tests added to the approved list (see FAQ question above for the list) is to have the prospective language proficiency testing vendor fill out the vendor application. The Oregon Council of Health Care Interpreters (OCHCI) will review the application and work with the vendor to determine if they can meet the requirements for language proficiency testing vendors in Oregon.

(New 9/2024) Will providers who took proficiency tests within the last four years need to retest after those four years have expired?

In-language providers do not need to retest if the proficiency test took place within four years from the CCO's initial validation and documentation date.

Who can I reach out with additional questions about the measure?

All additional questions can be sent to Metrics Questions at Metrics.Questions@odhsoha.oregon.gov.