The California Medicare Part D Language Access Coalition

Medicare Part D

"Please Hold" Medicare Plans Leave Limited English Proficient Beneficiaries Waiting for Access

December 2008

A report from

THE CALIFORNIA MEDICARE PART D LANGUAGE ACCESS COALITION WITH

THE ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

THE GREENLINING INSTITUTE

THE HEALTH CONSUMER CENTER OF LOS ANGELES

THE NATIONAL HEALTH LAW PROGRAM AND

THE NATIONAL SENIOR CITIZENS LAW CENTER

ACKNOWLEDGEMENTS

"Please Hold": Medicare Plans Leave Limited English Proficient Beneficiaries Waiting for Access was produced by the California Medicare Part D Language Access Coalition, an informal coalition of advocates in legal and community based organizations serving limited English proficient and low income communities in California.

The study was lead by the National Senior Citizens Law Center, The Greenlining Institute, the National Health Law Program, the Asian & Pacific Islander American Health Forum and the Health Consumer Center of Los Angeles. The National Senior Citizens Law Center was the primary author of this report.

Individuals from the following organizations contributed extensive time and energy to the survey by completing calls: Asian & Pacific Islander American Health Forum, Asian Pacific American Legal Center, California Welfare Rights Organization, Family Bridges, the Greenlining Institute, Health Consumer Center of Los Angeles, Health Rights Hotline, Korean Resource Center, Legal Services of Northern California, National Senior Citizens Law Center, Ombudsman Services of Northern California, PALS for Health and ALAS para Tu Salud and Southeast Asian Action Resource Center.

Hilda Morales, Summer Associate at the Greenling Institute, coordinated the implementation of the survey and Kendra Nicole Scalia conducted the statistical analysis. Nancy Arévalo, NSCLC Public Interest Law Assistant, and Sahar Naseery, NSCLC Administrative Assistant, assisted with data collection and entry.

Questions about this report can be directed to Kevin Prindiville, NSCLC Staff Attorney, at kprindiville@nsclc.org or 510-663-1055.

TABLE OF CONTENTS

EXECUTIVE SUMMARY…….. i

INTRODUCTION…… 1

PURPOSE……..... 3

METHODOLOGY IN BRIEF……..... 3

KEY FINDINGS…….…..... 4

CALLER EXPERIENCES…….…..... 5

CONCLUSIONS…….…..... 12

RECOMMENDATIONS……. 13

APPENDIX A. METHODOLOGY……..... 16

APPENDIX B. DEMOGRAPHICS OF DUAL ELIGIBLE POPULATION IN CA……. 18

APPENDIX C. SUCCESSFUL CALLS BY LANGUAGE……... 19

APPENDIX D. QUANTITATIVE METHODS……. 20

EXECUTIVE SUMMARY

Three years into the Medicare Part D program, Medicare prescription drug plans continue to fail to meet their obligations to provide multi-lingual services to limited English proficient (LEP) Medicare beneficiaries. During the summer of 2008, the California Medicare Part D Language Access Coalition, led by the National Senior Citizens Law Center, the Greenlining Institute and the National Health Law Program, designed and conducted a survey to assess Medicare prescription drug plan call center service to LEP populations. The survey, which used the same methodology employed in an earlier survey conducted by the Coalition in 2006, focused on the 9 prescription drug plans into which California's dual eligibles (individuals with Medicaid and Medicare) are enrolled. The survey placed 339 calls in 10 of the 13 most common languages spoken by dual eligibles in California. Results of the 2008 survey indicate that, while plans have made some improvements in their ability to connect callers to someone speaking their language, LEP Medicare beneficiaries in California continue to struggle to attain meaningful access from Medicare Part D plans.

Key Findings

Plans' call centers continue to fail to serve significant numbers of beneficiaries, showing only modest improvements compared to the 2006 survey results. In 2008 plan sponsors are able to serve limited English proficient dual eligible beneficiaries, after weighting for language prevalence among the dual eligible population, 69% of the time (up from 55% in 2006). Non-Spanish speaking LEP beneficiaries are connected to someone speaking their language, after weighting, 57% of the time (up from 37% in 2006).

Caller Experiences

The majority of survey calls that did not connect to someone speaking the language of the caller ended without even an attempt to connect the caller. Nearly 70% of the calls that connected to a live speaker, but did not ultimately connect to someone speaking the test language ended without an attempt to connect. The remaining 30% ended after an unsuccessful attempt.

Struggles connecting were not confined to particular languages. No language, not even Spanish, saw more than 80% of calls successfully connected to someone who spoke the language of the caller.

Refusal by a plan customer service representative (CSR) to provide service in any language other than English was the most common reason for a failed call. In other cases, the call failed after the plan representative failed to correctly identify the language of the caller or when an attempt to connect with an interpreter was unsuccessful.

Even when callers connected to someone speaking their language, they often did not get the information they were seeking. Beneficiaries who connected to someone speaking their language frequently encountered interpreters who failed to interpret accurately or follow basic standards of interpretation, long wait times and unhelpful or rude customer service representatives.

Interpreters failed to translate accurately or in the first person too often. Many interpreters struggled with basic medical and health systems terminology. Others violated basic interpreter standards by failing to translate fully or interpret in the first person. A lack of familiarity among CSRs with protocols for interpreter-facilitated communication also contributed to miscommunication.

Plans relied heavily on third party interpreter services; bi-lingual representatives were rare. A third party interpreter was used in 85% of the calls that connected to someone speaking the language of the caller. A bilingual CSR was never provided in a language other than Spanish and even Spanish calls were regularly handled by interpreters.

Receiving assistance from an interpreter, as opposed to a bilingual customer service representative, increased wait times. On average, callers who were connected to an interpreter waited four minutes and fifty-five seconds before speaking to someone in their language (starting from the time the phone is answered by the plan). This is a significant wait time for a LEP caller who likely did not understand anything the plan representative said before being placed on hold. Callers who were served by bilingual CSRs only waited an average of one minute and thirty-three seconds.

Customer service quality was low. Only 40% of plan customer service representative were rated as "very helpful," while 16% were described as rude. The customer service quality of interpreters was not much better with only 51% receiving a "very helpful" rating.

Limited English proficient callers were not able to get written materials in their language. During each of the 201 calls in which the caller was connected to someone speaking their language, the caller asked whether written materials were available in their language. While plans claimed a number of times to have materials available in non-English languages, no materials in languages other than English or Spanish were ever actually received.

Recommendations

The survey results show that while plan performance has improved somewhat in the last two years, plans are still falling short of their obligation to provide services to limited English proficient beneficiaries. The Coalition has provided previously detailed recommendations to plans in both the earlier report as well as a best practices document prepared at the request of CMS.[1] Plans should refer to the recommendations in those documents as they work to improve services. The results of the new survey highlight a few areas where plan attention could lead to significant improvements for LEP beneficiaries.

- **Improve customer service and language assistance training for all plan staff that interact with beneficiaries, including specifically procedures for identifying**

[1] The report from the 2006 survey, "Medicare Prescription Drug Plans Fail Limited English Proficient Beneficiaries" is available at www.nsclc.org/areas/medicare-part-d/Part-D-Library/Reports-and-Studies/Medicare-Plans-Fail-LEP. "Best Practices: Serving Limited English Proficient Medicare Beneficiaries" is available at www.nsclc.org/areas/medicare-part-d/Part-D-Library/Reports-and-Studies/Plan-Best-Practices

limited English proficient beneficiaries and connecting them to interpreters or bilingual staff. Although all plans have some sort of arrangement to provide language assistance services to LEP beneficiaries, not all CSRs know that the service exists and that they are required to use it. Even those CSRs who know the service exists and want to use it are not all properly trained on utilizing the service. More training is required to ensure that CSRs are able to connect callers to interpreters and do so with courtesy and respect.

- **Hire more bilingual staff.** Plan call centers are relying heavily on interpretive services staffed by individuals who are not sufficiently familiar with Medicare, Part D and plan details and terminology. Hiring more bilingual staff that can communicate directly with LEP beneficiaries would improve access.

- **Ensure that third party interpreters are fluent, culturally competent speakers with health systems literacy and training in basic interpreter standards.** Interpreters must be more than fluent speakers. They must also be culturally competent, have a familiarity with the health systems terms that apply to Part D and be well trained in the skill and standards of interpretation.

- **Produce written materials in a variety of languages and train CSRs about the availability of these materials and procedures for providing them to callers.** The survey results show that plans either have not translated materials or their CSRs do not know how to get translated materials to beneficiaries. Plans should produce non-English materials and train CSRs on the availability of materials and procedures for sending language appropriate information to callers.

In January 2008 the Centers for Medicare and Medicaid Services sent a memorandum to all Medicare Advantage and Prescription Drug plans reminding them of the requirement that they serve LEP beneficiaries and providing them with best practices. CMS should take the following additional steps to ensure plan compliance with requirements of federal law:

- **Require plans to develop and share with CMS comprehensive and detailed strategies for serving limited English proficient beneficiaries.**

- **Monitor plan call center service to LEP beneficiaries.** Monitoring efforts should evaluate not only connection rates, but the ability of LEP beneficiaries to actually access information during the call.

- **Monitor whether plans have translated materials into key languages.** Plans should be required to provide to CMS a list of materials they produce and the languages into which each of those materials has been translated. A copy of the translation should be provided to CMS as verification.

- **Take corrective action against plans that fail to serve the LEP population.**

INTRODUCTION

The Medicare prescription drug program, known as Medicare Part D, is the federal program that offers prescription drug coverage to Medicare beneficiaries. Under the program, the Centers for Medicare and Medicaid Services (CMS), the federal agency charged with implementing and administering the program, contracts with competing private plan sponsors to provide prescription drug coverage to eligible beneficiaries within a defined service area. Part D is a complicated program which is difficult for beneficiaries to navigate.

Thousands of plans operate in multiple regions across the country. In 2008, California had 56 stand alone Prescription Drug Plans (PDPs) offered statewide and an additional 11 (Lassen County) to 110 (Los Angeles County) Medicare Advantage Prescription Drug Plans (MA-PDs) offered in each county.[1] In 2009, there will be 51 PDPs offered across California and an additional 6 (Lassen) to 55 (Los Angeles) MA-PDs in each county. Each of the plans provides different benefits at a different price.[2] Plans also have their own distinct network of pharmacists and processes for filing exceptions and appeals.

Medicare Part D's market-driven design requires that Part D beneficiaries "shop" for a plan. If they are to participate in the market as effective "shoppers," Medicare beneficiaries must be able to communicate directly with the plans, asking questions and getting reliable answers. A beneficiary who is shopping for a plan must be able to call to obtain information about that particular plan's costs and coverage. A beneficiary who is already enrolled in a plan must be able to contact the plan to obtain information about coverage, costs, pharmacy networks, exceptions and appeals, and more.

Recognizing that all beneficiaries have a right to access important plan information, CMS requires plan call centers to provide multi-lingual services to limited English proficient Medicare beneficiaries. The CMS requirement is straightforward and comprehensive: "Call centers must be able to accommodate non-English speaking/reading beneficiaries. Organizations should have appropriate individuals and translation services available to call center personnel to answer questions non-English speaking beneficiaries may have concerning aspects of the prescription drug benefit."[3]

If plans do not provide services to LEP beneficiaries in their language, beneficiaries will be unable to access important information about their prescription drug coverage. It is critical that plans take appropriate measures to provide services to LEP individuals.

In 2006 the California Medicare Part D Language Access Coalition undertook a study of Part D plans offered in California to determine how well they were able to serve limited English proficient beneficiaries. The results, which were disappointing, were shared with CMS. In January 2008, CMS wrote a memorandum to plans reminding them of their obligation and providing them with best practices for serving LEP beneficiaries.[4] In the summer of 2008, the Coalition conducted this study to determine the progress plans have made towards complying with the requirement that they provide service to LEP beneficiaries in their call centers.

Special Needs of Dual Eligibles

While the requirement that plan call centers provide language appropriate services is important for all LEP beneficiaries, it is particularly important for limited English proficient beneficiaries who are dual eligibles (individuals who receive both Medicare and Medicaid). There are more than six million dual eligibles nationally and approximately one million in California; more than one third of California's dual eligibles are limited English proficient.

Due to their complex medical needs, dual eligible beneficiaries are more likely to require assistance from their Part D plan than other Medicare recipients. Dual eligibles tend to be sicker and poorer than other Medicare beneficiaries. Twenty percent of dual eligibles report being in poor heath, compared to ten percent of the rest of the Medicare population.[5] Over fifty percent of all dual eligibles live below the federal poverty level ($10,400/year in 2008) and over ninety percent have incomes below 200% of the federal poverty level.[6] According to the Medicare Payment Advisory Commission (MedPAC), when compared to other Medicare beneficiaries, "dual eligibles are more likely to be female, African American, or Hispanic; lack a high school diploma; have greater limitations in activities of daily living; reside in a rural area; and live in an institution, alone, or with persons other than a spouse."[7]

The vulnerable health of dual eligibles makes accurate and timely communication with plans essential. In addition, their poverty increases the urgency of the need for appropriate assistance. While other beneficiaries might be able to pay the full cost of a prescription if a coverage problem arises, dual eligibles usually cannot afford to do so and are likely to go without needed medication if they do not receive assistance.

CMS has built some protections for dual eligibles into the Part D program. Dual eligibles automatically qualify for the Low-Income Subsidy ("Extra Help"), are automatically assigned to a "benchmark plan" by CMS if they do not affirmatively choose a drug plan and can switch plans at anytime during the year. These protections, however, do not make communication with plans any less vital for dual eligibles. For example, since auto-assignment does not take into account their drug needs, many dual eligibles have had to shop for and switch to a plan that better meets their needs.

Language access, which is an important right for all Part D beneficiaries, is an especially critical need for LEP dual eligibles.

PURPOSE

This survey was designed and conducted to determine whether the "benchmark plans" into which dual eligibles have been automatically enrolled are meeting the requirement that they provide language services to limited English proficient beneficiaries.

Specifically, we sought to discover the approximate rate at which a limited English proficient dual eligible beneficiary in California could expect to speak with a Medicare Part D Prescription Drug Plan (PDP) customer service representative or third party interpreter in his or her primary language. Recognizing that it is not sufficient to merely connect beneficiaries to individuals able to communicate in their language, the survey also sought to evaluate the quality of interpretation and other services provided to LEP callers. In addition, the survey addressed the wait times faced by LEP callers and the availability of written materials in languages other than English.

The survey uses the same methodology as a survey conducted by the Coalition in the Fall of 2006.

METHODOLOGY IN BRIEF

- All eight sponsors of the 2008 benchmark plans in California were surveyed.
- Calls were completed in ten languages:

Cantonese	Korean	Spanish
Cambodian (Khmer)	Lao	Tagalog
Farsi	Mandarin	Vietnamese
Hmong		

- Callers only spoke the designated language, except that the survey protocol permitted callers to use the English word for the test language (e.g., "Spanish") and/or a country associated with that language (e.g., "China").

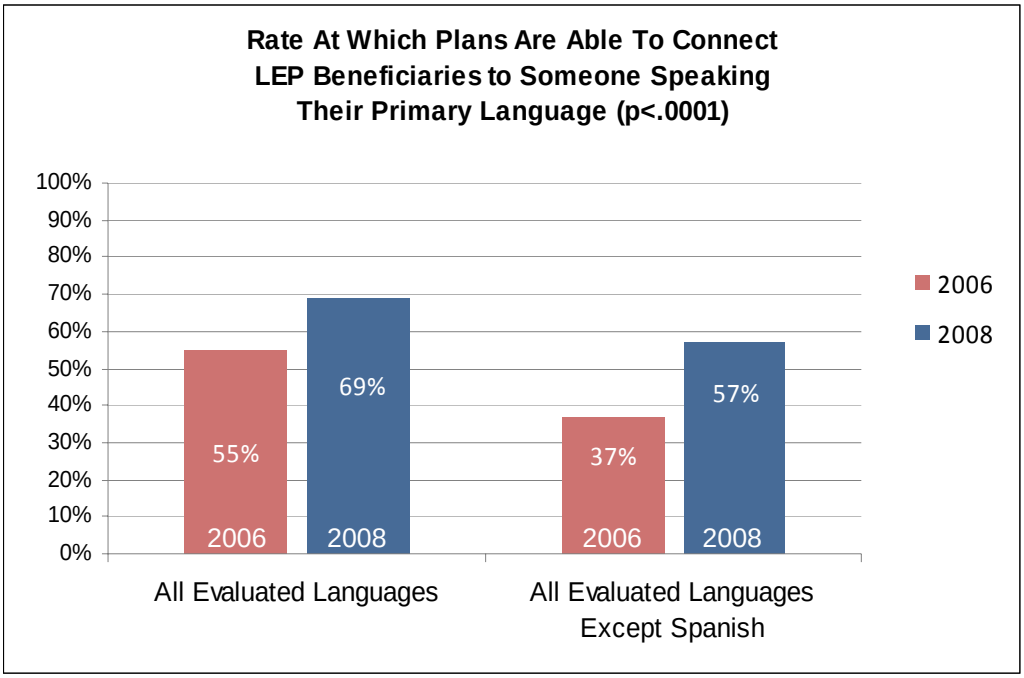
[*See Appendix A for a detailed discussion of the methodology of this survey.]*

KEY FINDINGS

Plan sponsors are only able to connect limited English proficient dual eligible beneficiaries to someone speaking their primary language 69% of the time.[8]

Non-Spanish speaking LEP beneficiaries have even less success communicating with their plans. Plan sponsors are only able to connect non-Spanish speaking limited English proficient dual eligible beneficiaries to someone speaking their primary language 57% of the time.[9] [S*ee Figure 1.*]

Figure 1



Survey results were weighted to reflect the relative prevalence of the test language within the dual eligible population. [*See Appendix D for quantitative methods.*]

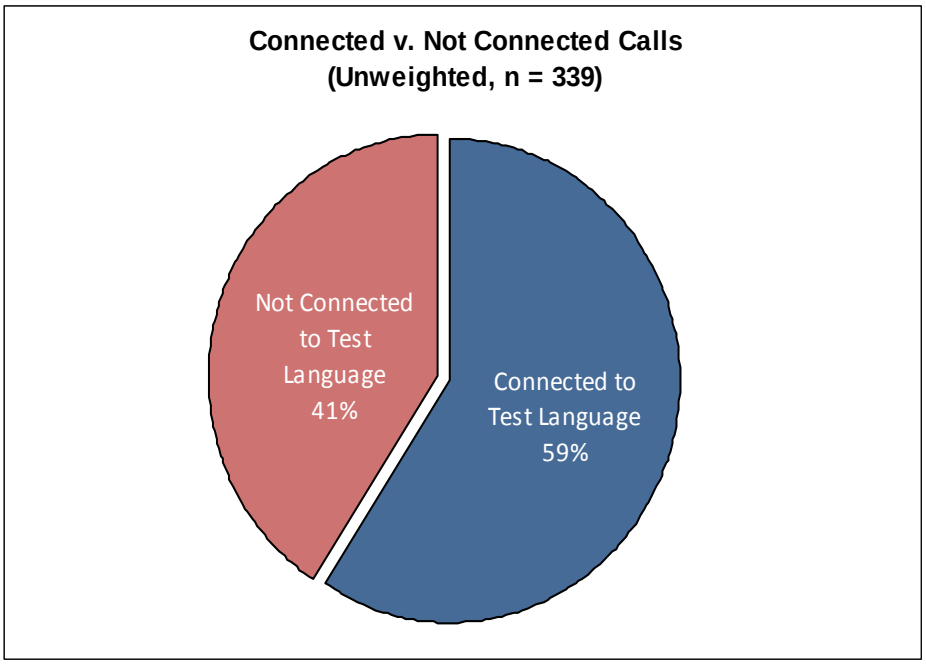
CALLER EXPERIENCES

The majority of calls that did not connect to someone speaking the language of the caller ended with no attempt to connect the caller.

Of the 339 calls made, over 40% never reached someone speaking the language of the caller.

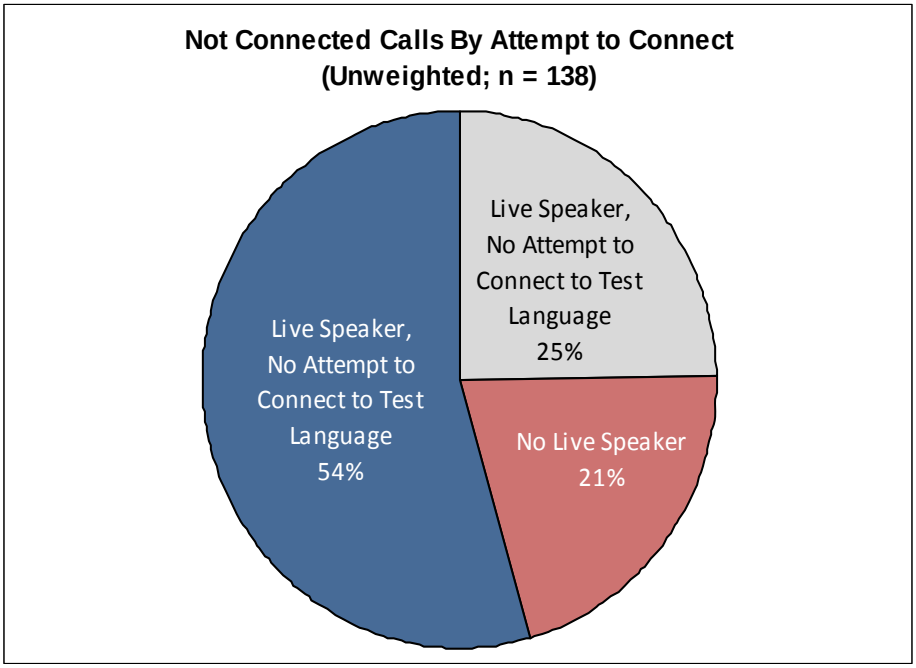
- Only 59% of calls were ultimately connected to someone who spoke the language of the caller (201 calls).
- 32% of calls connected to a live representative, but not to anyone speaking the caller's language (109 calls).
- The remaining 9% of calls did not connect to a live speaker (29 calls). [*See Figure 2.*]

Figure 2



Of the 109 connected to a live representative, but not to anyone speaking the caller's language, 75 ended without an attempt to connect the caller to an interpreter. In the remaining 34 calls, customer service representatives attempted to connect the caller but were unable to complete the connection. [*See Figure 3.*] In the majority of these calls, the caller was disconnected while waiting to connect to an interpreter.

Figure 3



Many of the calls that did not connect to any live speaker were routed to answering services that asked callers to leave a message with a name and phone number so that the call could be returned. Limited English proficient callers cannot use such systems because they are not able to understand the instructions or to leave a message in English.

Struggles connecting were not confined to particular languages.

The problems connecting occurred across all test languages and were not concentrated in the less prevalent languages. Spanish callers had the most success, connecting to someone speaking their language 80% of the time. Vietnamese callers had the least success, connecting to someone speaking their language just 38% of the time. [*See Appendix C for the total number of calls completed per language and the number of those calls which were successful.*]

Representatives failed to connect callers for a variety of reasons.

CSRs failed to connect LEP callers with someone speaking their language for a variety of reasons. On some calls, the CSR failed to identify the caller's need for services in a non-English language or misidentified the needed language. Much more common were CSRs who refused to provide services in a language other than English. There were also CSRs who tried to, but were unable to connect to an interpreter service. The experiences of callers provide examples of these failures. [*See box, Caller Experiences: Problems Connecting.*]

Caller Experiences: Problems Connecting

A Korean speaking caller requested, "Korean please." The plan CSR responded, "There's no one here by that name," and hung up.

A Vietnamese speaking caller explained, "Sorry. No English. Vietnamese." The CSR first asked very loudly and deliberately, "I-do-not-understand-you. How-can-I-help you?" When the caller repeated, "Vietnam" the CSR asked, clearly annoyed, who she was trying to reach. The caller repeated, "Sorry. No English. Vietnam," to which the CSR responded, "Ma'am, there's no one here by that name" and hung up.

A Vietnamese speaking caller explained "No English. Vietnamese." The CSR responded, "I'm sorry I did not understand that. Habla Español? Do you speak Spanish?"

A Korean speaking caller was connected to an Arabic interpreter. A Vietnamese speaking caller was provided with a Hindi interpreter. Several callers were asked to spell the language they needed after CSRs were unable to identify the language request.

A CSR explained to a Vietnamese speaking caller, before ending the call, "I'm sorry, I do not speak Vietnamese. My goal is to provide you with the best service, but I don't speak your language. Have a nice day."

A CSR insisted that a Cantonese speaker had to speak English to get service. Another told a Farsi caller who said, "No English, Afghanistan," that she had called the wrong number.

A Hmong caller was laughed at and told that he had called an English-only line and could not be helped. Another Hmong caller was told to call back with someone who spoke English.

After waiting on hold for a few minutes a Hmong caller was told, in English, that there was no Hmong interpreter available at the moment. Many callers reported spending a long time on hold while the CSR was reportedly attempting to connect to an interpreter service only to be disconnected before the CSR returned.

Even when callers connected to someone speaking their language, they often did not get the information they were seeking.

Beneficiaries who connected to someone speaking their language encountered interpreters who failed to interpret accurately or to follow basic standards of interpretation. Callers endured long wait times and unhelpful or rude customer service representatives. These elements combined to prevent many of callers from getting the information they were seeking from the plan – even though they had connected to someone speaking their language.

Interpreters failed to translate accurately or in the first person too often.

Callers evaluated the language proficiency of interpreters and bilingual customer service representatives as well as the frequency with which interpreters translated accurately and in the first person. While the language skills of interpreters and bilingual CSRs were generally strong, many interpreters struggled to interpret accurately or in the first person.

Language skill ratings were categorized into four skill levels: (1) *very well / excellent*, (2) *good / fair*, and (3) *not well*, and (4) *poor*. Individuals able to communicate effectively and understand complex or difficult phrasing were given a skill level rating of *very well / excellent* if no obvious lack of proficiency was demonstrated. Interpreters and CSRs who understood most of what the caller said and answered questions satisfactorily were rated as *good/fair*. Interpreters and CSRs given a rating of *not well* were unable to form complete sentences or struggled with simple non-English vocabulary. *Poor* interpreters and CSRs were only able to offer very limited responses to the caller's questions. Callers were instructed not to consider factors such as tone of voice or accent in assessing the quality of interpretation. Bilingual CSRs, though representing just a small portion of calls, performed slightly better than interpreters. [*See Figure 4.*]

Figure 4

Language Skill	Interpreters (n = 163)*	Bilingual CSRs (n = 29)*
Very Well	44% (71)	59% (17)
Good	41% (67)	28% (8)
Not Well	11% (18)	7% (2)
Poor	4% (7)	7% (2)

* Not all calls that connected contained a language skill rating

To measure interpreter accuracy, callers were asked the question, "Did you feel that the interpreter interpreted accurately and faithfully everything that you said to the customer service representative, and vice versa?" and were given three answers to choose from, "Yes," "No," or "Sometimes." For nearly 40% of the calls in which callers graded the performance of third party interpreters (63 of 162), callers reported that information was not always interpreted accurately. [*See Figure 5.*]

Figure 5

	Interpreted Accurately (n = 162)*		Interpreted in First Person (n = 162)*	
Yes	99	61%	84	52%
No	19	12%	44	27%
Sometimes	44	27%	34	21%

* Not all calls that connected to an interpreter contained an interpreter rating.

Callers were also asked the question, "Did the interpreter interpret in the first person voice?" and were given the same three choices to choose from, "Yes," "No," or

"Sometimes." Nearly 50% of interpreters failed to interpret in the first person throughout the call (78 of 162). [*See Figure 5.*]

Comments from the callers provide some examples of interpreters failing to translate accurately or follow standard protocol for interpreting. [*See box, Caller Experiences: Interpreter Problems.*]

Caller Experiences: Interpreter Problems

A Cantonese speaking caller noted that the interpreter "didn't know the difference between the proper terms and commonly used terms." During a Farsi call the interpreter, "kept using English words such as 'member' and 'ID number.'"

A Vietnamese caller found that the interpreter "was not really listening to my questions and tried to summarize the information." A Cantonese caller recorded a similar experience, "This interpreter was deciding what I needed instead of what the CSR or I said."

A Tagalog caller observed that co-pay information shared by the representative was not accurately translated by the interpreter.

During multiple calls the interpreter's inability to translate accurately was the result of a plan representative's failure to comply with basic protocols of interpretation such as waiting for the interpreter to finish interpreting before speaking. A Hmong caller noted, "Overall, it was kind of frustrating because the representative did not take the time to listen to my questions and answer thoroughly. She seemed like she was in a hurry to end the phone call with me."

A Cantonese caller was connected to an interpreter that did not know the terms for Medi-Cal or Medicare. When the representative learned that the caller was from California, she was put on hold and transferred to 1-800-MEDICARE.

Plans relied heavily on third party interpreter services instead of bilingual representatives.

A third party interpreter was used in 85% of the calls that connected to someone speaking the language of the caller. A bilingual CSR was never provided in a language other than Spanish and even Spanish calls were regularly handled by interpreters. Almost half of all Spanish calls were handled by an interpreter. [*See Figure 6.*]

Figure 6

	Spanish	Other Languages	Total
Total Calls Connected to the Test Language	59	142	201
Interpreter Used	28 (47%)	142 (100%)	170 (85%)
Bilingual CSR used	31 (53%)	0 (0%)	31 (15%)

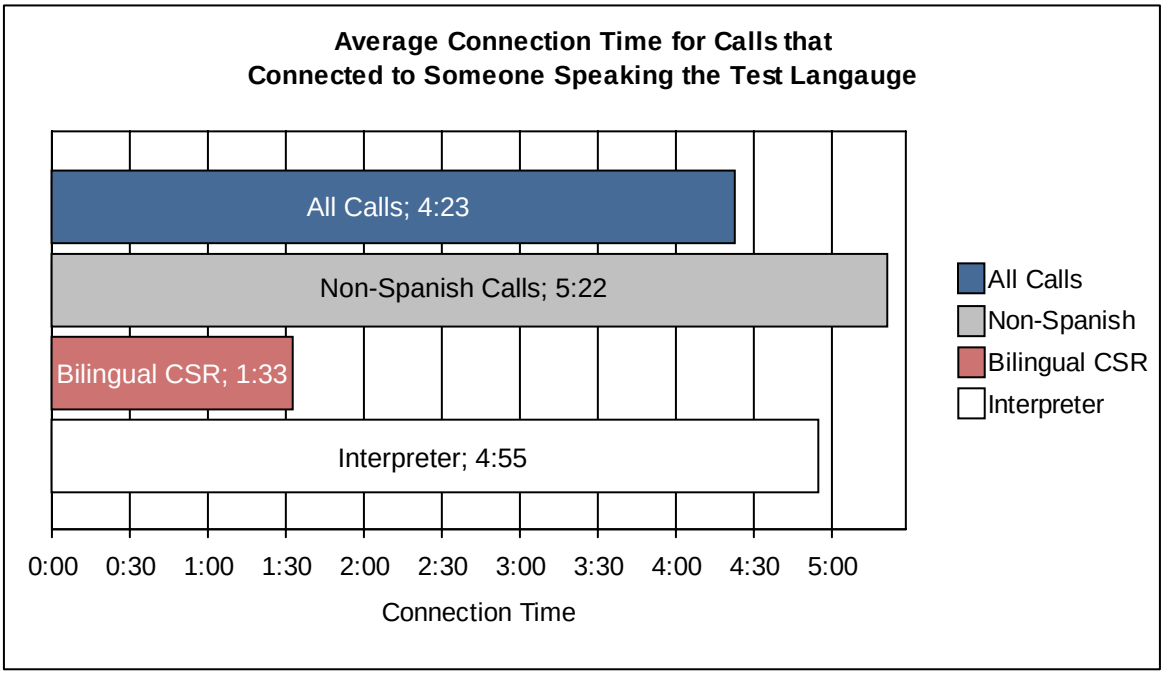
Receiving assistance from an interpreter, as opposed to a bilingual CSR, increased wait times.

The quality issues that arise when interpreter services are used are not the only drawback to relying heavily on interpreter services. The time it takes to connect to the service means that callers face longer wait times. Callers who were connected to an interpreter waited, on average, four minutes and fifty-five seconds (4:55) to connect to someone speaking their language (starting from the time the phone is answered by the plan) compared to an average wait of one minute and thirty-three seconds (1:33) for those who were connected to a bilingual CSR.

Across all callers, the average wait time was four minutes and twenty-three seconds (4:23). Excluding Spanish calls, the average wait time was five minutes and twenty-two seconds (5:22). Wait times for individual calls ranged from five seconds (0:05) to nearly twenty-six minutes (25:58). [*See Figure 7.*]

While a wait time of four or five minutes may not seem unconscionably high, for a LEP caller it represents a significant barrier. LEP callers are not likely to understand the information a customer service representative provides before putting the caller on hold. Asking the caller, in English, to hold or telling the caller, in English, to wait while an interpreter is found is not particularly helpful. During the survey, not a single non-Spanish speaking caller was told to hold in the test language. It is unlikely that many LEP callers will wait on hold for four or five minutes without any assurance that they are in the process of connecting to someone whom they can communicate with.

Figure 7



The quality of customer service provided to callers was low.

Only 40% of plan customer service representative were rated as "very helpful," while 16% were rated as rude. The customer service quality of interpreters was not much better with only 51% receiving a "very helpful" rating.

Customer service quality ratings were categorized into four levels: (1) *very helpful; excellent service*, (2) *somewhat helpful*, and (3) *not particularly helpful*, and (4) *rude unhelpful*. Callers consistently rated the customer service quality as less than "very helpful." Only 40% of plan customer service representative were rated as "very helpful," while 16% were rated as rude. The customer service quality of interpreters was not much better with only 51% receiving a "very helpful" rating. [*See Figure 8.*]

Figure 8

Quality	CSRs (n = 281)*		Interpreters (n = 153)*	
Very Helpful	113	40%	78	51%
Somewhat Helpful	64	23%	47	31%
Not Particularly Helpful	60	21%	22	14%
Rude	44	16%	6	4%

* Not all calls that connected to a CSR or interpreter contained a quality rating.

LEP callers were not able to get written materials in their language.

The 201 callers who connected with interpreters, except for those who were cut off prematurely, asked the question "Do you have written materials in (*language*)?" Plan representatives indicated that written materials were available in the requested language only eighteen times (twelve times in Spanish, twice in Tagalog and once each in Cantonese, Farsi, Korean and Vietnamese). No non-Spanish or non-English materials were ever actually received. The survey did not determine whether the responses reflected an actual lack of written materials or ignorance by plan representatives of their existence.

CONCLUSIONS

While plans have made some improvements in their ability to connect limited English proficient beneficiaries to someone speaking their language, they are still falling short of providing meaningful access to this vulnerable population. The requirement that plan call centers serve LEP beneficiaries is clear and undisputed. Per CMS marketing guidance:

> Call centers must be able to accommodate non-English speaking/reading beneficiaries. Organizations should have appropriate individuals and translation services available to call center personnel to answer questions non-English speaking beneficiaries may have concerning aspects of the prescription drug benefit.[10]

Rates at which callers were successful in reaching an individual who spoke their language remain unacceptably low. Although it appeared that all of the surveyed plans have established affiliations with language assistance services, many plan representatives continue to be unaware of the existence of interpretation services and did not even try to connect to a language assistance organization.

Even those callers who did connect with someone speaking their language did not get the information they needed. Callers who connected faced long wait times and had difficulty dealing with interpreters and customer service representatives who did not interpret accurately, failed to follow standards of interpretation and provided unsatisfactory customer service.

An additional problem highlighted by the survey was the fact that callers are still not able to access written Part D plan information in their language. As in the 2006 survey, plan representatives were, during the vast majority of calls, unaware if any such material existed. Most assumed written materials were only available in English. CMS regulations require that marketing materials and enrollment forms be translated in markets "with a significant non-English speaking population."[11]

RECOMMENDATIONS

This report recommends that Medicare Part D plans and the Centers for Medicare and Medicaid Services take immediate action to address Part D's systemic failure to appropriately serve limited English proficient beneficiaries. Although this report surveyed only a portion of California's Part D plans, the federal requirements to provide services to LEP individuals apply to all Medicare Part D plans including both stand-alone and Medicare Advantage Prescription Drug Plans.

The survey results show that while plan performance has improved some in the last two years, plans are still falling short of their obligation to provide services to LEP beneficiaries. The Coalition earlier provided detailed recommendations to plans in both the report on the 2006 survey[12] and a best practices document prepared at the request of CMS.[13] Plans should refer to the recommendations in those documents as they work to improve services. The results of the current survey highlight a few areas where plan attention could lead to significant improvements for LEP beneficiaries.

- **Improve customer service and language assistance training for all plan staff that interact with beneficiaries, including specifically procedures for identifying LEP beneficiaries and connecting them to interpreters or bilingual staff.** It is clear that all plans have some sort of arrangement to provide language assistance services to LEP beneficiaries. Unfortunately, not all CSRs know that the service exists and that they are required to use it. Even those CSRs who know the service exists and want to use it are not all properly trained on utilizing the service. More training is required to ensure that CSRs are able to connect callers to interpreters.

- **Hire more bilingual staff.** Plan call centers are relying heavily on interpretive services staffed by individuals who are not sufficiently familiar with Medicare, Part D and plan details and terminology. Hiring more bilingual staff who can communicate directly with LEP beneficiaries would improve access. Of course, plans must take appropriate steps, such as testing applicants who claim to be bilingual and training bilingual CSRs on Part D concepts and terms, to ensure that bilingual CSRs provide quality, accurate service to LEP beneficiaries.

- **Ensure that bilingual CSRs and third party interpreters are fluent, culturally competent speakers with health systems literacy and, for interpreters, training in basic interpreter standards.** Bilingual CSRs and interpreters that plans contract with must be more than fluent speakers. They may also be culturally competent, have a familiarity with the health systems terms that apply to Part D and, with regard to interpreters, well trained in the skill and standards of interpretation.

- **Produce written materials in a variety of languages and train CSRs about the availability of these materials and procedures for providing them to callers.** The survey results reveal that plans either have not translated materials or their

CSRs do not know how to get translated materials to beneficiaries. Plans should produce non-English materials and train CSRs on the availability of materials and procedures for sending language appropriate information to callers.

In January 2008, the Centers for Medicare and Medicaid Services sent a memorandum to all Medicare Advantage and Prescription Drug plans reminding them of the requirement that they serve LEP beneficiaries and provided them with best practices for meeting their obligation. CMS should take the following additional steps to ensure plan compliance with requirements of federal law:

- **Require plans to develop and share with CMS comprehensive and detailed strategies for serving LEP beneficiaries.** Requiring plans to submit these strategies to CMS will ensure that they are created. Having the details from plans will allow CMS to better monitor plan compliance with language requirements.

- **Monitor plan call center service to LEP beneficiaries.** Monitoring efforts should evaluate not only connection rates, but the ability of LEP beneficiaries to actually access information during the call.

- **Monitor whether plans have translated materials into key languages.** Plans should be required to provide to CMS a list of materials they produce and the language that each of those materials has been translated into. A copy of the translation should be provided to CMS as verification.

- **Take corrective action against plans that continue to fail to serve the LEP population.** CMS should make use of the full array of tools available – including sanctions and contract termination – when dealing with non-compliant plans.

Failure to provide language assistance services, both oral interpretation and written translations, will further existing health disparities between limited English proficient populations and all other individuals. Without adequate access to information, LEP beneficiaries cannot fully participate in the Medicare Part D prescription drug program and, as a result, may not appropriately access the benefits, resulting in serious negative health and financial outcomes for the beneficiaries and economic costs for the communities and states where they live.

All Medicare Part D beneficiaries need information and service, particularly vulnerable dual eligible LEP individuals. It is the responsibility of CMS and the plans to ensure that LEP beneficiaries can access necessary information in their primary language in order to appropriately utilize essential health services.

[1] Data drawn from "2008 MA-PD Landscape Source" and "2008 SNP Landscape Source." Source data *available at*: www.cms.hhs.gov/PrescriptionDrugCovGenIn.

[2] Data drawn from "2009 MA-PD Landscape Source" and "2009 SNP Landscape Source." Source data *available at*: www.cms.hhs.gov/PrescriptionDrugCovGenIn.

[3] Centers for Medicare and Medicaid Services, "Medicare Marketing Guidelines," p. 115, *available at*: www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FinalMarketingGuidelines.pdf. Also see Addendum 2 of the Guidance, "Customer Service Call Center Requirements."

[4] CMS Memorandum to plans, "Best Practices for Addressing the Needs of Non-English Speaking and Limited English Proficient (LEP) Beneficiaries" *available at*: www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/MemoLEPBestPractices_01.02.08.pdf

[5] Medicare Payment Advisory Commission (MedPAC) "Chapter 3: Dual-eligible Beneficiaries" June 2008 Data Book, Health Care Spending and the Medicare Program, *available at*: http://www.medpac.gov/chapters/Jun08DataBookSec3.pdf

[6] Id.

[7] Id.

[8] Margin of error: ± 4.91.

[9] Margin of error: ± 5.96.

[10] CMS, "Medicare Marketing Guidelines" (see note 3).

[11] 42 C.F.R. §423.50(d)(5). See also CMS, "Medicare Marketing Guidelines," at 115, "Organizations should make marketing materials available in any language that is the primary language of more than ten percent of a plan's geographic service area" (see note 3).

[12] Kendra Scalia with the National Senior Citizens Law Center and the California Medicare Part D Language Access Coalition, "Medicare Prescription Drug Plans Fail Limited English Proficient Beneficiaries," *available at*: www.nsclc.org/areas/medicare-part-d/Part-D-Library/Reports-and-Studies/Medicare-Plans-Fail-LEP.

[13] National Senior Citizens Law Center, National Health Law Program and the California Medicare Part D Language Access Coalition, "Best Practices: Serving Limited English Proficient Medicare Beneficiaries," *available at*: www.nsclc.org/areas/medicare-part-d/Part-D-Library/Reports-and-Studies/Plan-Best-Practices

APPENDIX A. METHODOLOGY

Eight Medicare prescription drug plan sponsor telephone hotlines offering nine benchmark stand-alone Prescription Drug Plans (PDPs) [1] were evaluated in ten non-English languages. A total of 339 calls were completed. All calls were made between July 1, 2008 and August 15, 2008 during the hours of 8:00 A.M. and 6:00 P.M., Pacific Standard Time, Mondays through Fridays.[2]

Telephone hotlines operated by each of the plan sponsors were derived from the 2008 Medicare & You Handbook. All seven sponsors were surveyed in each language approximately equally. Below is a list of sponsors.

- Blue Cross of California
- Bravo Health
- First Health Part D
- Health Net
- HealthSpring Prescription Drug Plan
- RxAmerica
- Unicare
- WellCare

The survey evaluated the following languages: Cantonese, Cambodian (Khmer), Farsi, Hmong, Korean, Lao, Mandarin, Spanish, Tagalog and Vietnamese. Speakers of these languages represent nearly 28% of dual eligible recipients in California. The other three most common languages spoken by dual eligibles in California, Armenian, Arabic and Russian, were not included due to the unavailability of callers in those languages.

Bilingual speakers, all of whom were professional employees or volunteers associated with non-profit organizations across California, called each sponsor hotline to request information in their native non-English language.

Callers posed as monolingual speakers for the duration of the call and were instructed not to respond to or reply in English except to request interpretive services. At the beginning of each call, callers asked, in their non-English language, if the customer service representative spoke their language. If they were not successful, they were instructed to follow up by repeating the English name of their language and/or the country of origin of their language in an effort to connect to an interpreter or plan sponsor employee able to communicate in their test language. Callers recorded whether they were successfully connected to an interpreter or plan representative who spoke their language and the

[1] One plan sponsor, Unicare, offered two benchmark plans in California in 2008.

[2] Plan sponsors are "required to operate a toll-free call center for both current and prospective enrollees that operates seven days a week at least 8:00 A.M. to 8:00 P.M. according to the time zones for the regions in which they operate." Centers for Medicare and Medicaid Services, "Medicare Marketing Guidelines," Addendum 2, "Customer Service Call Center Requirements" *available at*: www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FinalMarketingGuidelines.pdf. To maximize translator availability, survey calls were limited to the 8:00 a.m.-6:00 p.m. timeframe.

circumstances (e.g., operator hung up without attempting a transfer, attempted a transfer and was successful, attempted a transfer and was disconnected, etc.). Automatic disconnections by the plan sponsor hotline when unable to handle the volume of incoming calls, as well as those calls disconnected by volunteer callers after excessive hold time were counted as disconnected calls. Calls that were routed to an English voicemail box were also counted as disconnected calls. Calls where callers encountered a busy signal were not included in the survey.

If they successfully reached a speaker of their language, callers followed a script[3] in which they were to request information in the test language for their hypothetical dual eligible relative.[4] In order to more accurately evaluate the quality of the interpreter's language skills, callers were instructed to engage the interpreter in conversation. The script consisted of the following four groups of questions, which were designed to evaluate language skills in the test language. Callers were instructed to ask one question from each group:[5]

GROUP I:

(1) "I am calling for my mother. She has Medicare and Medi-Cal. Do you have a plan for her?" or
(1a) "My father has Medicare and we have some questions. He needs a plan, and he is on Medi-Cal." or
(1b) "I am calling for my uncle who is on Medicare and Medi-Cal. We want to find out about your least expensive plans."

GROUP II:

(2) "Does your plan cover drugs that do not need a prescription?" or
(2a) "Can he use your plan at my local pharmacy" or
(2b) "Do you cover over-the-counter drugs?"

GROUP III:

(3) "Is there an enrollment deadline?" or
(3a) "When can he sign up?"

GROUP IV

(4) "Do you have written materials in (language)?"

Callers completed an individual evaluation form for each call considered complete. Complete calls are all calls made to a plan sponsor in which the caller did not encounter a busy signal. The evaluation included a quality rating for calls in which callers were connected to someone speaking their language.

[3] Pre-testing in both Spanish and Farsi prior to the start of data collection demonstrated that the text was workable.

[4] Callers requested information on behalf of a hypothetical dual eligible relative rather than themselves due to the difficulties of receiving information from Part D plans without providing specific personal information. Whereas specific personal information (i.e. Medicare identification number, address, full name and birth date) may be difficult to withhold, a caller may appear to have sufficient reason to withhold information regarding another individual for reasons such as privacy concerns or lack of knowledge.

[5] Responses to these questions were not evaluated for accuracy.

APPENDIX B. DEMOGRAPHICS OF DUAL ELIGIBLE POPULATION IN CA

Figure 9.

Demographics of CA Dual Eligibles*		
Languages	**No. of Dual Eligibles by Language**	**% Dual Eligible CA Beneficiaries****
All Sign Languages	596	0.1%
Arabic	2,990	0.3%
Armenian	20,893	2.0%
Cambodian	3,931	0.4%
Cantonese	32,577	3.1%
English	493,803	47.1%
Farsi	11,042	1.1%
Hmong	2,132	0.2%
Korean	14,533	1.4%
Lao	2,103	0.2%
Mandarin	15,380	1.5%
Other Chinese	3,483	0.3%
Other Non-English	15,100	1.4%
Russian	15,723	1.5%
Spanish	160,635	15.3%
Tagalog	19,210	1.8%
Unknown	200,492	19.1%
Vietnamese	34,666	3.3%
Grand Total	1,049,289	100.0%

* **SOURCE**: California Department of Health Services, Medical Care Statistics Section. "Medi-Cal Beneficiaries by Age/Demographics," April 2008.
** Due to rounding, percentages do not total exactly to 100%

APPENDIX C. SUCCESSFUL CALLS BY LANGUAGE

Figure 10

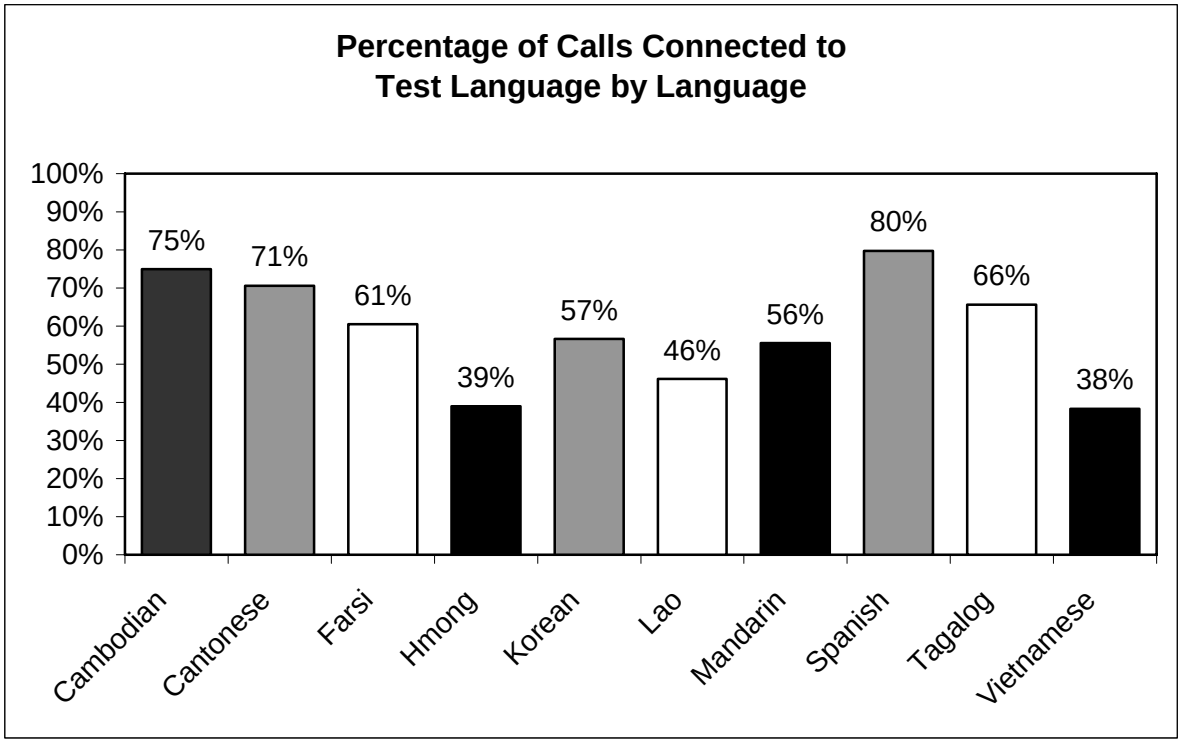


Figure 11

Calls Connected to Test Language by Language			
Language	**Total Calls**	**Total Connected Calls**	**% Success per Language**
Cambodian	8	6	75.00%
Cantonese	34	24	70.59%
Farsi	38	23	60.53%
Hmong	41	16	39.02%
Korean	30	17	56.67%
Lao	26	12	46.15%
Mandarin	9	5	55.56%
Spanish	74	59	79.73%
Tagalog	32	21	65.63%
Vietnamese	47	18	38.30%
TOTAL	339	201	59.29%

APPENDIX D. QUANTITATIVE METHODS

We calculated the weighted response rate ($\bar{u}$) by summing the products of each language response rate (r_i) and the weight of each language (w_i). Weights were derived per language strata with a simple quotient of the rate of the language use within the population (X_L) and the rate of the language use within our sample (x_L). The following formula was used to calculate weights and the weighted response rates, as well as the margin of errors:

Weight per strata and weighted response rate:

$$w_i = \frac{X_L}{x_L}$$

$$\bar{u} = \sum [r_i \cdot w_i]$$

Margin of error:

$$\bar{u} \pm 1.96 \cdot \sqrt{\frac{(1-u)\cdot u}{n}}$$

Key

w_i = weight	X_L = rate of language use within population	n = sample size
r_i = response rate per language	x_L = rate of language use within sample	$\bar{u}$ = weighted response rate

Statistical hypothesis testing was completed using an independent two-sample z-test with a 95 percent confidence interval ($\alpha = 0.01$). Our hypotheses are that there is no difference between the ability of Spanish speaking callers and callers of all other test languages in reaching someone who spoke the test language and that there is no difference between the ability of all test languages and all languages not including Spanish in reaching someone who spoke the test language.

The following are the hypothesis testing formulas for an independent two-sample z-test:

$$H_o: \bar{u}_1 = \bar{u}_2$$

$$z = (\bar{u}_1 - \bar{u}_2) \Big/ \sqrt{\frac{\sigma_1}{n_1} + \frac{\sigma_2}{n_2}}$$

Our results reject the null hypothesis and assert that there is a significant difference between the ability of Spanish speaking callers and callers of all other test languages in reaching someone who spoke the test language ($p<.0001$); the results also assert that there is a statistical difference between the ability of all test languages and test languages not including Spanish in reaching someone who spoke the test language ($p<.0001$).