

POLICY AND PROCEDURE

DEPARTMENT: Quality Improvement	DOCUMENT NAME: Cultural Competency and Linguistic Assistance Policy (C&L)
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APPROVED DATE:	RETIRED: N/A
EFFECTIVE DATE: 03/16/21	REVIEWED/REVISED: 03/25/21
PRODUCT TYPE: Medicaid	REFERENCE NUMBER: LA.QI.CLAS.29

SCOPE:

Louisiana Healthcare Connections (LHCC) This policy impacts all employees and departments in Louisiana Healthcare Connections (LHCC). Each department is required to meet the cultural and linguistically appropriate service (CLAS) Standards that are interwoven in their core business areas.

PURPOSE:

To provide clarity regarding the provision of cultural and linguistic services in accordance with regulatory and managed care contract requirements. This includes the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards), as developed by the U.S. Department of Health and Human Services Office of Minority Health and Section 1557 of the Affordable Care Act. The scope of this policy covers:

- **Health literacy and plain communication**
- **Language services**
- **Reduction of health disparities**
- **Cultural competency capabilities**
- **Support for members with disabilities**

LHCC is committed to developing, strengthening and sustaining healthy provider/member relationships. Members are entitled to dignified, appropriate and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process. Providers should note that the experience of a member begins with their first interaction with the health plan. Failure to use culturally competent and linguistically competent practices could result in the following:

- **Feelings of being insulted or treated rudely**
- **Reluctance and fear of making future contact with the office**
- **Confusion and misunderstanding**
- **Treatment non-compliance and poor health outcomes**
- **Feelings of being uncared for, looked down upon, or devalued**
- **Parents resisting to seek help for their children**
- **Unfilled prescriptions**
- **Missed appointments**
- **Misdiagnosis due to lack of information sharing**

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- Inefficient use of resources
- Increased grievances or complaint
- Litigation

POLICY:

The Company (LHCC) provides culturally appropriate health care. Services are provided in an accessible and responsive manner to all beneficiaries, including those with diverse cultural and ethnic backgrounds, diverse health beliefs and practices, limited English proficiency, disabilities, and differential abilities, regardless of race, color, national origin, sex, sexual orientation, gender identity, preferred language, or limited health literacy, free of charge. The Company implements processes that assure the health care services provided have the flexibility to meet the unique needs of members.

Cultural competency within LHCC is defined as the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural competency is developmental, community focused, and family oriented. In particular, it is the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods throughout the system to support the delivery of culturally relevant and competent care. It is also the development of skills and practices sensitive to cross-cultural interactions, and encouragement of practices that ensure services delivered in a culturally competent manner.

STANDARDS:

The Company (LHCC) accomplishes culturally appropriate services through the following standards:

I. Identifying the cultural, linguistic, disparity and accessibility needs of members

The Company will:

- a. Collect and Maintain Member Demographic Information – the Company maintains a membership database to capture member demographic information including race, ethnicity, preferred language, alternate format preferences and

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disability status received from various sources such as enrollment forms and membership files. Data collected using these methods has the ability to be aggregated to The Executive Office of the President of the United States: Office of Budget and Management (OMB) race and ethnicity classifications, unless state or federal enrollment data is submitted using a different classification process. Data is uploaded into membership records with the ability to generate member level reporting. Members may be informed of the need to collect demographic information through newsletters, annual or targeted mailings, contact with Member Services and/or member websites. Members will be informed at the point of data collection the permissible and impermissible uses of race and ethnicity data.

- b. A demographic analysis of member composition by race, ethnicity, preferred language, age group, and sex is conducted annually. The Company uses census data, indirect race/ethnicity estimations and local data sources to create a demographic profile when member reported data is not sufficient. The Company analyzes provider linguistic and cultural concordance with member demographics.
- c. Conduct *Disparity Assessments* – The Company annually assesses its quality improvement program to identify targeted Healthcare Effectiveness Data and Information Set (HEDIS) measures with a focus on population size and disparities that if addressed, will have the ability to improve metrics such as minimum performance levels and STAR ratings. Data sources for disparity analysis can include publically available aggregate data identifying health outcome disparities or health plan member data. Identified targets are presented to quality committees for discussion on the development of tailored interventions to support disparity reduction. Selected metrics are tracked and monitored and outcomes of disparity reduction projects are reported to quality committees.
- d. Produce a *Cultural Competency Work Plan* – the Company develops and annually updates a Cultural Competency Plan (CCP), in consultation with representatives from diverse cultural communities. The CCP includes, at a minimum:
 - a. An organizational commitment to deliver culturally appropriate health care services.

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- b. A work plan that establishes goals and objectives and covers the areas of health literacy, cultural competency, language services, health disparities and disability accessibility.
- c. A timetable for implementation and accomplishment of the goals and objectives.
- d. An organizational chart showing the key staff persons with overall responsibility for cultural services and activities. Qualifications of staff, including appropriate education, experience, and training shall also be described. RFP 4.2 Key Staff Positions
- e. Standards and performance requirements for the delivery of culturally appropriate health care services based on federal/state standards with delineation as needed by product (i.e. Medicare, Medicaid, Exchange)
- f. Committee Reporting: Cultural and linguistic reporting is provided annually to CLAS Task Force, then to the Quality Assessment and Performance Improvement Committee (QAPIC) to ensure integration of (Cultural Competency and Linguistic Assistance Policy) C&L into organization functions and support resolution of C&L barriers. Reporting includes elements I a-c.

II. Ensuring members fully understand the health care and services available to them, that they have the opportunity to participate in their own care, and have the right information to make informed decisions

The Company will:

a. Document Cultural/Linguistic/Disability Provider Access Capabilities – Update Provider Directories in accordance with state contract and regulatory requirements, to reflect the cultural, linguistic, and/or disability access capabilities of contracted providers including:

- i. Disability Access – the Company has a system to document disability access of contracted providers and information on provider access capabilities are made available in the provider directory.
 - a. Refer to policy MCARE.PRVS.10 Access and Availability for provider accessibility requirements pertaining to physical accessibility and LHCC’s Provider Accessibility Initiative.
- ii. Cultural Competency – Contracted providers confirm completion of ongoing cultural competency training and this information is uploaded into the Company’s provider directory

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- iii. **Linguistic capabilities – Contracted providers document office staff and provider non-English language capabilities. Providers documenting non-English language capabilities are attesting to meeting the standards for “qualified” bilingual staff per Section 1557 of the Affordable Care Act (ACA). Providers are required to attest that they and their staff have the appropriate skills, knowledge and qualifications to provide bilingual services in accordance with state and federal guidelines. Providers must retain documentation demonstrating compliance with these requirements and furnish this information upon request.**
- iv. **Provide Medical Care and Information on Treatment Options – Contracted providers are expected to provide medical care, information, and treatment options in a manner that is respectful of diverse cultural beliefs, health literacy levels, and disability access needs, as well as preferred language choices. This includes, but is not limited to, a member’s ability to obtain, process, and understand information.**

b. Maintain compliant provider directories and provide appropriate support services

- i. **Update Provider Directories in accordance with state contract and regulatory requirements, to reflect any changes in the cultural, linguistic, and/or disability access capabilities of contracted providers.**
- ii. **Offer Support Services to connect members with cultural, linguistic, and disability-responsive community health and social service resources.**

c. Meet the needs of members for language support and appropriate member materials

- i. **Provide High Quality Interpreter and Linguistic Services: free of charge, in a timely manner, for limited English proficient (LEP) members or potential members in all languages, including American Sign Language, at all key points of contact through a variety of formats. Services will be provided accurately and protect the privacy and independence of members with LEP.**

a. Policy Statements

- i. **The Company evaluates and arranges for qualified interpreter services at the time of the appointment that is appropriate to the patient and the situation. Methods of interpreter services include telephonic and Face 2 Face.**

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- ii. **The Company provides communication services in support of members who are visually impaired and deaf or hard of hearing.**
 - 1. **The Company Call Centers provides access to video relay or TTY lines to deaf or hard of hearing members/enrollees, their support person(s), and potential members/enrollees upon request.**
 - 2. **The Company provides American Sign Language for in-person communication for members who are deaf or hard of hearing.**
- iii. **Bilingual staff: Only Company staff who have passed a bilingual assessment are eligible to use their bilingual skills to facilitate non-clinical communication. The Company ensures bilingual staff English proficiency through interview, hiring and annual training/evaluation requirements. For clinical interpretation, the Company only uses contracted interpreter vendors who meet interpreter quality standards.**
- iv. **The Company and participating providers facilitates access to language services and documents a request and/or refusal of services in the plan or the provider’s member data system.**
 - 1. **Use of family, friends and minors for interpreters: Federal law prohibits Providers and Company staff from requiring or recommending that members provide an interpreter, including ASL, or use friends or family to provider interpreter services.**
 - 2. **Minors: A minor child can only be used as an interpreter in an emergency involving an imminent threat to the safety or welfare of the individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available.**
 - 3. **Adults: An accompanying adult may be used to interpret or facilitate communication in an emergency involving imminent threat to the safety and welfare of an individual or the public where there is no qualified interpreter available or, when the individual with limited English proficiency specifically requests that the accompanying adult interpret, the accompanying adult agrees to provide such assistance, and reliance on that**

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adult for such assistance is appropriate under the circumstances.

- b. Quality standards for interpreter services are included in each interpreter vendor contract. Interpreter quality standards include:
 - i. Standards to adhere to generally accepted interpreter ethics principles, such as those published by the National Council for Interpreting in Health Care, including patient confidentiality;
 - ii. Demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language
 - iii. Demonstrated ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

- c. Quality Standards for Bilingual Staff
 - i. Bilingual providers and staff are considered qualified to provide language services if they have a demonstrated proficiency in speaking and understanding both English and at least one other language, including any necessary specialized vocabulary, terminology, and phraseology; are able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary language. The Company will verify language capability of providers and staff who provide bilingual services and will document the languages spoken in the provider directory.

- d. Interpreter Services are available as required by contract or regulation.

- e. Interpreter services are coordinated with the scheduling of appointments in a manner that ensures that interpreter services are available at the time of the appointment.

- f. Interpreter services must be provided to facilitate communication between the Company and the member/enrollee.

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- i. Interpreter services must be provided at all applicable points of contact**

 - 1. Points of contact include, but are not limited to medical care settings such as patient encounters, interactions with pharmacists, diagnosticians, laboratory technicians.**
 - 2. Points of contact include non-medical care settings such as member services, appointment scheduling or orientations.**

- ii. Interpreter services are provided without imposing an undue delay on the scheduling of the appointment.**

- g. Informing members of the availability of language services, including interpreter services and alternate formats.**

 - i. The Company notifies all new and renewing members/enrollees of the availability of language services through methods such as websites and member handbooks.**

 - 1. The organization’s member handbook:**

 - a. Informs members how to access auxiliary aids and services.**
 - b. Is available upon request.**
 - c. Is available free of charge.**
 - ii. The Company includes a notice of Non-Discrimination with all significant communications sent to members. The significant communication includes all Non-Discrimination elements required by federal rules or regulations.**
 - iii. All significant communications that include Non-Discrimination information also includes a notice advising the member of the availability of language assistance services (aka taglines).**
 - iv. The Company notifies members/enrollees of the following:**

 - 1. The availability of qualified interpreters.**
 - 2. Their right to request or refuse interpreter services.**
 - 3. Members/enrollees may request interpreter services without compromising the effectiveness of services.**

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4. The provider may not request or require that the member bring their own interpreter.
5. Minors can only be used as interpreters when there is an emergency.
6. The availability of sign language interpreters.
7. The use of family and friends as interpreters is permitted if it is appropriate to the situation and both the patient and the accompanying adult agree to act as interpreters.

h. Provider language services notification

- i. The Company notifies contracted providers, including specialty plans, of the availability of no-cost interpreter services and oral translation services through Company Provider Operations Manual and other methods as determined by the Company. Notification will include:
 1. The types of interpreter services available at no cost from the Company.
 2. Information on how to arrange for interpreter services.
 3. The limitations on the use of bilingual staff, minors or accompanying adults as interpreters.

i. Monitoring of interpreter services

- i. The Company monitors interpreter and oral translation services provided for effectiveness.
- ii. The Company requires that interpreter, sign language, video remote interpretation and oral translation services meet the standards of quality necessary to each point of contact as required by law, regulatory agency, contract, or oversight agency.
- iii. The Company requires that contracted interpreters and oral translators have received education and training in interpreter ethics, conduct and confidentiality.
- iv. The Company conducts, at minimum, every other year business reviews of contracted interpretation service vendors that include performance review to determine if quality standards were met.

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- v. **The Company reviews member/enrollee complaints and grievances related to the delivery of interpreter services.**

- ii. **Provide Translated Member Materials in non-English Threshold Language and Alternate Formats:**
 - a. **Threshold/prevalent languages**
 - i. **The Company establishes and publishes prevalent languages for all lines of business annually, inclusive of identification of emerging languages that are trending toward becoming a threshold language. The Company coordinates any new prevalent/emerging languages with impacted departments to ensure coordination of material development.**

 - b. **Requirements for Translations and Alternate Formats**
 - i. **Non-English languages: The Company provides required translated materials in threshold/prevalent languages in accordance with state and federal requirements for mailed materials and materials available electronically. At a minimum, these materials are provided upon request by the member. The Company follows all State, MMP and Medicare regulations related to the requirements of standing requests as applicable. MMP and Medicare plans provide materials in non-English prevalent languages as a standing request. A standing request is a process that is used to make materials available to the member in threshold languages at the time of request and on an ongoing basis thereafter.**

 - ii. **Alternative Formats: Under Section 1557 of the Affordable Care Act, Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, federally conducted and assisted programs along with programs of state and local government are required to make their programs accessible to people with disabilities as well as provide effective communication. Effective communication means to**

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communicate with people with disabilities as effectively as communicating with others. Any documents sent by the Company or our delegate(s) are made available upon request in an alternate format. Once a member’s alternate format preference is known, MMP and Medicare members receive their materials in their preferred alternate format as a standing request.

- iii. **Oral Translations: To ensure timeliness for access to medical information and/or for languages and/or materials that do not meet state and federal requirements for written translations, the Company, at a minimum, provides oral translations in all languages (including members who have visual impairments) by facilitating a reading of the material to the member in their preferred language through use of qualified bilingual staff and/or Company interpreter vendors.**

- c. **Quality requirements: The Company ensures that all non-English translations and alternate formats meet the standards of quality required by law, regulatory agency, contract, or oversight agency. The Company uses contracted vendors for all non-English translations and braille. Translation vendors provide an attestation of quality for all materials CMS requires an attestation for all translations including alternate formats for materials provided to Medicare and MMP members. Document owners are responsible for requesting this from the vendor fulfilling this request.**

- 1. **Monitoring of the translation and alternate format process is conducted by the Company and includes:**
 - a. **Monitoring grievances that are related to alternate formats, taking corrective actions to address the grievance issues, tracking of grievances to identify trends, and collecting information on the performance of alternate format vendors.**

 - b. **Oversight of the vendors for quality standards, turn-around times and monitoring vendor performance.**

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- c. Monitoring of workbaskets and workgroups with LHCC line of business Project Managers to identify barriers and develop solutions to support quality translation processes.
- d. Ensure Website Accessibility: The Company’s website and content posted to the website meets the accessibility guidelines published by the Web Accessibility Initiative and outlined in Section 508 of the Rehabilitation Act of 1973.
- iii. Develop information on community resources that support the ethnic and diverse make-up of the member community with a focus on resources that support the social determinants of health.
- iv. Written materials in plain language: the Company ensures that all member materials are written in plain language and are culturally sensitive taking into consideration language proficiencies, type of disabilities, literacy levels, cultural variation, age-specific targeted learning skills and ability to access and use technology. Materials will be written in Sans Serif font using a font size of 12 or larger. When requested, or as required by regulators, materials in Large Print text is produced in font size 18 or larger. Unless otherwise specified in state contracts, plain language is determined as no greater than an 8th grade reading level for Medicare and Marketplace and 6th grade reading level for Medicaid/MMP. The Company uses readability testing on all materials to ensure plain language standards are met.

III. Create a safe, accessible, and welcoming environment at key points of contact.

The Company and contracted providers share responsibility for:

- i. Education and Training – Staff, including governance and leadership, providers and ancillary services such as home health, receive ongoing education and training to ensure cultural competency. The Company offers training, education, information and/or consultation on cultural and linguistic services to contracted providers and internal departments on a regular basis.
- ii. Workforce Development – The Company supports workforce development by recruiting, hiring, developing and promoting a culturally, linguistically, and disability-diverse workforce, including leadership, that reflects the diversity

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- of the membership and has a familiarity with the counties served, cultural norms, and how people access health care.
- iii. Intervention development – the Company uses the annual assessment; including disparity analysis, to coordinate interventions in partnership with quality improvement, utilization management and care coordination.

IV. Holding the Company and contracted providers, vendors and ancillary plans accountable to provide high quality health care and services that are accessible and culturally and linguistically responsive.

- a. Contracted providers will, as previously noted, Document Cultural/Linguistic/Disability Access Capabilities, as described in section II (a) (i) above.
- b. The Company will:
 - i. Establish and Maintain community linkages and provide documentation of community partnership.
 - ii. Document Cultural/Linguistic/Disability Access Capabilities, as described in section II (a) (i) above.
 - iii. Develop Quality Assurance Standards for cultural, linguistic, and disability access services to ensure the quality, accuracy, and timely delivery of these services at all points of contact for emergency, urgent, and routine health care services.
 - iv. Evaluate the Cultural, Linguistic, Disparity and Disability outcomes annually.
 - v. Conduct audits of vendors and ancillary plans for compliance with cultural and linguistic requirements.
 - i. Submission of annual reports that document language services provided, member demographic analysis of members served, P&Ps, training and bilingual staff certification. Reporting is aligned to ensure that quality interpreter standards are met through all vendors and ancillary plans that are not using Company language services.
 - ii. Internal review of vendor and ancillary plan P&Ps to ensure compliance with federal and state standards for C&L, as often as

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required per policy CC.COMP.21 Third Party Oversight Program Description.

- iii. Participate in recurring Joint Oversight Committees (JOCs) with vendors who provide C&L services and review monthly or quarterly metrics and barriers. JOCs will also produce CAPs and support resolution of identified issues.
- iv. Provision of Corrective Action Plan when vendors and ancillary plans are not in compliance with identified standards.

- vi. Perform Quality Assurance Oversight for providers – Perform quality assurance oversight of contracted providers to ensure compliance with the regulatory requirements related to cultural, linguistic, and disability access, on a regular basis. Activities may include: desktop review of policies and procedures and on-site review. The Company monitors member satisfaction and access to C&L services through Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and appeals and grievances.

- vii. Both the Company and Contracted Providers will: Inform Members of Right to File Grievance – Ensure members receive information regarding a member’s right to file a grievance and seek an independent medical review in threshold, concentration standard languages, and in alternative formats and other languages, upon request.

- c. The Company will additionally:
 - i. Provide Access to Grievance System – Ensure members have access to and can participate in the grievance system. By participating in the grievance system, members receive, at a minimum, written translations and/or oral interpretation of grievance procedures, materials written in plain language. Easily understandable notification includes a complete explanation of the reason for the denial in plain language that does not include abbreviations or acronyms that are not defined, health care codes that are not explained, or medical jargon that a layperson would not understand), as well as access to auxiliary aids & services that assist members with disabilities.

 - ii. Track and Report Grievances – Track members’ complaints and grievances, including reporting related to discrimination, cultural, linguistic, and disability access.

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REFERENCES:

External References: Culturally and Linguistically Appropriate Standards (CLAS), Office of Minority Health; Americans with Disabilities Act (ADA), Title II and Title III; Civil Rights Act of 1964; Section 1557 of the Affordable Care Act (ACA); National Association of Social Workers (NASW) Practice Standards & Guidelines; Medicare Marketing Guidelines; Medicaid Managed Care Rules; NCQA Health Plan Standards and Guidelines 2020; NCQA Distinction in Multicultural Health Care (MHC) Guidelines (1-5); NCQA Population Health Management (PHM) Guidelines; Centers for Medicare and Medicaid Services (CMS) Code of Federal Regulations (CFR), CMS Criteria for Medicaid Managed Care Contract Review and Approval, Plain Writing Act of 2010; U.S. Code § 18031 Affordable choices of health benefit plans.

Internal References: CC.COMP.42 Section 1557 Nondiscrimination in LHCC Health Care Programs and Activities, CC.COMP.21.02 Third Party Corrective Action Process, Found Policy, CC.MRKT.14 Web 508 Compliance, CC.HUMR.75 Disability Accommodation, CC.HUMR.02 Equal Employment Opportunity & Affirmative Action, CC.COMP.21 Third Party Oversight Program Description

DEFINITIONS:

Alternate Formats — auxiliary aids used to effectively communicate printed information to people who are blind or have low vision or people who have other functional impairments. Text produced in audio formats, electronic formats, large print, braille and accessible PDFs.

Ancillary Plan — an additional health insurance plan entity that may provide extra “ancillary” services including services including vision, dental care, behavioral health care, etc.

Auxiliary aids and services — include, as defined in 45 CFR 92.4, (2) Qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials; accessible electronic and information technology; or other effective methods of making visually delivered

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materials available to individuals who are blind or have low vision; (3) Acquisition or modification of equipment and devices; and (4) Other similar services and actions.

Qualified bilingual/multilingual staff— a member of a covered entity’s workforce who is designated by the covered entity to provide oral language assistance as part of the individual’s current, assigned job responsibilities and who has demonstrated to the covered entity that he or she: (1) is proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology and phraseology, and (2) is able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary languages.

Braille — a tactile system of print in which the characters are represented by tangible points or dots.

Contract Provider — an individual provider, clinic, group, association, vendor or facility employed by or under a provider agreement with the contractor to furnish physical health, behavioral health or long-term care covered services to the contractor’s members under the provisions of this agreement.

Culture — includes, but is not limited to, history, traditions, values, family systems, and artistic expressions of client groups served in the different cultures related to race and ethnicity, immigration and refugee status, tribal status, religion and spirituality, sexual orientation, gender identity and expression.

Cultural Competence — a set of congruent behaviors, attitudes and policies that come together in a system or agency or among professionals that enables them to work effectively in cross-cultural situations. Cultural competency involves integrating and transforming knowledge, information and data about individuals and groups of people into specific clinical standards, service approaches, techniques and Marketing programs that match an individual’s culture to increase the quality and appropriateness of health care and outcomes.

Electronic Format — text that is produced for use with digital equipment such as email, computer programs, screen readers or electronic players such as MP3 players.

Grievance — an expression of dissatisfaction about any matter or aspect of the contractor or its operation, other than a contractor adverse benefit determination.

Health literacy — a person’s ability to read, understand, and act upon health information.

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PAGE: 17 of 19	REPLACES DOCUMENT: N/A
APPROVED DATE:	RETIRED: N/A
EFFECTIVE DATE: 03/16/21	REVIEWED/REVISED: 03/25/21
PRODUCT TYPE: Medicaid	REFERENCE NUMBER: LA.QI.CLAS.29

Health literacy level — the degree to which members are able to obtain, process and understand basic health information and services needed to make appropriate health decisions.

Large Print — text produced in Times New Roman or similar font style in font size 14 or larger as required by regulator.

Limited English Proficient (LEP) — an inability or limited ability to speak, read, write, or understand the English language at a level that permits effective Interaction with health care providers or plan employees.

Linguistic Competence (Capabilities) — providing readily available, culturally appropriate oral and written language services to limited English proficiency (LEP) (with the exception of Native American languages for which there are not written forms and/or for which the State has not obtained consent from Tribal leadership to use the language) members through such means as bilingual/bicultural staff, trained medical interpreters, and qualified translators.

Major subcontractors — an entity with which the contractor has, or intends to have, an executed agreement to deliver or arrange for the delivery of any of the covered services under the agreement.

Marketing materials — materials that are produced in any medium, by or on behalf of the contractor that can reasonably be interpreted as intended to market to a recipient or potential member.

Member — a person who has been determined eligible for the Company’s plan and who has enrolled in the contractor’s managed care organization (MCO).

Oral Interpretation — the process of understanding and analyzing a written text in one language and re-expressing that message faithfully, accurately, and objectively in a spoken or signed language, taking cultural and social context into account.

People-first language — a type of linguistic prescription to avoid marginalization or dehumanization (either conscious or subconscious) when discussing people with a health issue or disability. It can be applied to any group that would otherwise be defined or mentally categorized by a condition or trait (for example, disease, age, disability, or appearance).

Plain language — information focused on readers. It is also referred to as “plain English”. Materials written in plain language allow the readers to quickly and easily find what they need, understand what they find, and act appropriately on that understanding.

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Points of contact — instances in which a member accesses the services covered under a plan contract, health insurer’s policy or certificate, including administrative and clinical services, telephonic and in-person contacts where the need for language assistance may be reasonably anticipated.

Provider — an institution, facility, agency, physician, health care practitioner, or other entity that is licensed or otherwise authorized to provide any of the covered services in the state in which they are furnished. Providers include individuals and vendors providing services to members through the self-directed community benefit.

Qualified interpreter for an individual with limited English proficiency — an interpreter who via a remote interpreting service or an on-site appearance: (1) adheres to generally accepted interpreter ethics principles, including client confidentiality; (2) has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and (3) is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

Source language — the language in which the statement or conversation originated. For the purposes of bilingual assessment the source language is English.

Standing Request — a process that is used to make materials available to the member in threshold languages at the time of request and on an ongoing basis thereafter.

Subcontractors — an entity with which the contractor has, or intends to have, an executed agreement to perform any functions required under the agreement and does not include a provider or contract provider.

Target language — the language into which the statements are converted.

Threshold language — a language spoken by a minimum number or percentage of members.

Translation — the conversion of a written text in one language (source language) into a written text in a second language (target language) corresponding to and equivalent in meaning to the text in the first language.

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Tribal — denoting an Indian or Alaska Native tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C.

REVISION LOG

REVISION:	DATE:
NEW POLICY	03/25/21
RETIRING LA.COMP.50 Organizational Cultural Competency	03/25/21

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in our P&P management software is considered equivalent to a physical signature.