March 31, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 314G
200 Independence Ave. SW
Washington, DC 20201

RE: FY 10 CMS Strategic LEP Plan Outcome Report

Dear Dr. Berwick,

The undersigned organizations are pleased to submit comments and feedback on CMS' Strategic LEP Plan Outcome Report. As you know, almost 20% of the population speaks a language other than English at home. Over 24 million, or 8.7% of the population, speak English less than very well and should be considered limited English proficient (LEP) for healthcare purposes.[1] This includes 47% of Spanish speakers, 33% of speakers of other Indo-European languages, 49% of speakers of Asian and Pacific Islander languages, and 30% of speakers of other languages.

Numerous studies have documented the problems associated with a lack of language services, including one by the Institute of Medicine, which stated that:

> Language barriers may affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision-making, or ethical compromises (e.g. difficulty obtaining informed consent). Linguistic difficulties may also result in decreased adherence with medication regimes, poor appointment attendance, and decreased satisfaction with services. (Cites omitted.) [2]

We thus applaud CMS development of its LEP Plan and welcome the opportunity to provide comments and feedback. The remainder of this document provides more detailed feedback on particular aspects of the Plan.

We urge CMS to continue its work on implementing this plan and expanding its language services. CMS' language services are supported by Executive Order 13166 which extended the application of Title VI to the federal agencies themselves. The Attorney General recently released a memo, *Federal Government's Renewed Commitment to Language Access Obligations Under Executive Order 13166*, reaffirming the Administration's commitment to providing effective language services. In addition, § 1557 of the Patient Protection and Affordable Care

[1] American Community Survey, 2006-2008, *Selected Social Characteristics in the United States: 2006-2008*; also American Community Survey, 2008, *Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over*, Table B16001, available at http://factfinder.census.gov.
[2] Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health*, at 17 (2002).

Act forbids discrimination on the grounds of sex, race, national origin, disability or age in health programs or activities receiving federal financial assistance or by programs administered by an Executive Agency or any entity established under Title I of the ACA. Because § 1557 applies broadly to federally conducted programs and to entities that receive federal funding or assistance, it is essential that CMS consistently take the requirements of §1557 into account. As CMS' activities are administered by an Executive Agency, we recommend that the Departments clarify that the LEP Plan also is essential to ensuring effective implementation of § 1557.

CURRENT STATUS

1-800-MEDICARE

We appreciate that the 1-800-MEDICARE helpline offers bilingual staff and access to interpreters. We believe that this is an important resource for LEP Medicare enrollees to receive information.

We also support the Plan's recognition of the need for a comprehensive notification plan and look forward to providing feedback as CMS consults with stakeholders. We suggest that CMS consider a public outreach campaign, particularly utilizing ethnic media, to improve knowledge of this service and heighten awareness of the availability of services in non-English languages that. We also suggest that, on the inside cover of the Medicare & You Handbook, CMS include a multi-lingual page with taglines in multiple languages. This page would inform recipients that free language services are available through 1-800-MEDICARE in multiple languages to provide enrollees with information. This can be an easy method of educating Medicare beneficiaries who may be limited English proficient but are receiving the Handbook in English.

To assist State Health Insurance Counseling and Assistance Programs (SHIPs) who provide services to LEP clients, we also suggest that CMS expand the scope of its telephonic interpreting contract to allow access to SHIPs to communicate with LEP clients. CMS could provide an access number for each SHIP to allow tracking and monitoring and the SHIP would benefit from having ready access to telephonic interpreters when needed to supplement competent in-house or on-site language services.

We also support the Plan's recognition of the need for a comprehensive notification plan and look forward to providing feedback as CMS consults with stakeholders.

TRANSLATION OF VITAL MEDICARE DOCUMENTS

We are extremely supportive of the decision of CMS to translate 160 Medicare vital documents into 15 languages (in addition to Spanish and English). For years, many organizations have been asking CMS to translate these federal forms that must be used by all Medicare providers across the country with millions of LEP Medicare beneficiaries. As Medicare providers are subject to Title VI and EO 13166, they have each had an individual responsibility to translate vital documents such as these forms. This has created unnecessary

costs, redundancies and inefficiencies as multiple providers may translate the forms multiple times. With over 5,000 hospitals in the U.S., one could imagine the costs and resources needed if each hospital had to evaluate the need for and translate many of these documents. We strongly encourage CMS to ensure that funding is available for any translation that is done.

Further, we ask that CMS create a quality assessment process for translation that ensures adherence to industry best practices. CMS must also recognize that some trans-adaptation – and not mere rote translation – may be needed due to cultural and linguistic nuances. We suggest CMS utilize the experience of stakeholders who have expertise in developing high-quality standards and processes for translation.

However, given that the translation process is outlined to take three years, we suggest CMS begin using "taglines" on these vital documents on an interim basis. We suggest that CMS include a tagline in at least 15 languages on all of the vital documents or as an attachment to the vital documents. The development of the tagline is an easy process and should not involve significant cost or time. CMS can adopt existing taglines from other agencies or organizations. For example, California's tagline is available in 13 languages. As another example, the Arizona Department of Economic Security has a "Language Notification Flyer" that states – "If you need this notice translated into your language, please call xxx-xxx-xxxx or xxx-xxx-xxxx." The notice includes 23 languages – 9 of which are included in SSA's 15. HHS could request permission to use California and/or Arizona's taglines and CMS could merely insert its number in place of the state's numbers. HHS could then translate the tagline into other prevalent languages, using the SSA languages as a guide or USDA which translates SNAP information into 37 languages.[3] This is a small price to pay to ensure language access for LEP enrollees and reduce the burdens on healthcare providers and community based organizations.

Further, having a standardized tagline utilized on all Medicare vital documents utilized by enrollees will assist LEP individuals who may receive multiple documents to be able to recognize the standardized language. It is also important that the tagline be written in an appropriate literacy level, such as a sixth grade reading level, so that LEP individuals can understand the tagline. The issue of health literacy is a growing problem in the United States. As mentioned in our introduction, more than 90 million Americans have low health literacy and this includes many of the LEP individuals as well. So having a standardized tagline written at a low "register" (literacy level) can also assist in comprehension.

As a suggestion, the tagline could read:

"IMPORTANT: You can get an interpreter at no cost to obtain information about this document. To get an interpreter or to ask about written information in (your language), call 1-800-MEDICARE. Someone who speaks (your language) can help you. "

We also suggest that CMS include translation in the process each time a vital document is approved or revised. That is, as a vital document goes through internal processes for approval, the last step after approval from OMB should include translation of the form into 15 languages plus Spanish. By having the translation as an integral part of a forms approval or renewal

[3] http://www.fns.usda.gov/snap/outreach/translations.htm.

process, CMS will ensure that forms are continually available in multiple languages as they are newly adopted or updated. Without this step, CMS could end up with a revised form available in English and only have prior versions translated. Thus, the plan outlined in the Report is an important first step but CMS must also ensure that translation is an ongoing process that is integrated into CMS' ongoing operations.

ELEMENT 1

We appreciate that CMS has developed a methodology to determine the number of limited English proficient beneficiaries served by CMS. However, we disagree with CMS' adoption of a 10% threshold. For oral language or interpreter services, we do not believe that there should be any threshold, as recognized by the HHS Office for Civil Rights' "LEP Guidance". If CMS utilizes a 10% threshold, it is likely that thousands of Medicare enrollees will have no access to assistance or information in their primary language. If a Medicare Prescription Drug and Health Plan is conducting outreach to an LEP population, and specifically if it is providing written information in a non-English language, the plan must be able to answer a potential enrollee's questions about the document prior to or after enrollment. And all enrollees should have access to oral information in their language, particularly for individuals for whom translated documents are not available.

For written translations, the OCR LEP Guidance sets a safe harbor for translation of vital documents at 5% or 1,000 individuals in a particular language. Since the efforts of CMS related to translation will benefit all Medicare providers subject to Title VI, we believe that CMS should adopt the same standard that Medicare providers are subject to pursuant to the LEP Guidance. We believe this standard of 5% or 500[4] individuals in a particular language group should apply throughout all of HHS and CMS.

We support CMS' documentation of language services provided through 1-800-MEDICARE but we believe CMS should go further and collect primary language data for all Medicare enrollees, including primary oral and written language needs. First, the data collection provision of the Patient Protection and Affordable Care Act requires this (§ 4302). Second, regardless of the PPACA provision, having accurate data on individual enrollees – rather than general population data available from the Census or data on the self-selected group that calls 1-800-MEDICARE – is critical to accurate and efficient planning for the provision of language services. Further, as many Medicare enrollees may not know that 1-800-MEDICARE provides interpreters, many enrollees may not be accessing this service and thus CMS is likely to be missing the full picture of those who would benefit from having robust language services provided. Third, having this data and transmitting it to Medicare providers would assist them in

[4] While we recognize that the HHS LEP Guidance sets safe harbor thresholds at 5% or 1,000 individuals, we recommend adoption of a lower number that is used by the Department of Labor in regulations governing large health plans. DOL's threshold is 500 or 10%. Thus our suggestion is to combine the 5% threshold from HHS and the 500 individuals from DOL. Since CMS as an entity is larger than any large insurance plan, we believe that it should be held at least to the same standards as these plans, particularly since work undertaken by CMS to translate documents provides significant benefits to thousands of Medicare providers who will use the translated documents.

identifying language needs of their patients, including the language needs in the patient's records, and accurately planning to provide language services.

ELEMENT 2

We support CMS' expansion of its language services and also recommend that CMS ensure that the language services provided are competent. For example, the Report notes that some SHIP counselors and CMS staff speak non-English languages. The question arises whether these individuals are sufficiently proficient in the non-English language to provide services directly to enrollees/clients. And if these individuals are interpreting for other SHIP or CMS staff, are these individuals trained as interpreters to understand the ethics, standards of practice, and other skills needed by interpreters. Without any assessment of the competency of those providing services directly in a non-English language or as interpreters, CMS runs the risk of having enrollees/clients receive inaccurate or incomplete information because of ineffective communication. We suggest that CMS provide explicit guidelines regarding when individuals (staff, caseworkers, etc.) can provide services in a non-English language or can interpret for other staff. These guidelines should include a language proficiency assessment and, for those serving as interpreters, training in the knowledge, skills and abilities needed of healthcare interpreters.

These guidelines or policies should also outline why family members, friends or untrained staff should not be used as interpreters. Significant problems can arise from the use of family members, friends and particularly children, rather than trained professionals, as interpreters. Adult family members or friends who act as interpreters often do not interpret accurately. Untrained interpreters are prone to omissions, additions, substitutions, and volunteered answers. For example, family members and friends often do not understand the need to interpret everything a patient/client says, and may summarize information instead. They may also inject their own opinions and observations, or impose their own values and judgments as they interpret. Family members and friends who act as interpreters may themselves have limited English language abilities and may be completely unfamiliar with complex terminology utilized during the conversation. We recommend using the HHS Office for Civil Rights' "LEP Guidance" as a guide to ensure the competency of interpreters and translators.

ELEMENT 3

We disagree with the 10% threshold for translating written documents and recommend that CMS adopt the threshold from the HHS Office for Civil Rights' "LEP Guidance". The Guidance sets a safe harbor for translation of vital documents at 5% or 1,000 individuals in a particular language. Since the efforts of CMS related to translation will benefit all Medicare providers subject to Title VI, we believe that CMS should, at a minimum, utilize the same standard that Medicare providers are subject to. But we recommend CMS adopt a standard of 5% or 500 individuals in a particular language group should apply throughout all of HHS and CMS (see footnote 4 above).

ELEMENT 5

As stated above, we support CMS' efforts to notify LEP individuals about the availability of free language services. We also suggest that CMS include in the Medicare & You Handbook taglines in multiple languages on the inside front cover, informing recipients that information on Medicare is available through 1-800-MEDICARE in multiple languages. This can be an easy method of educating Medicare beneficiaries who may be limited English proficient but are receiving the Handbook in English.

Again, we also suggest that CMS include taglines in at least 15 languages on all of the vital documents or as an attachment to the vital documents. The development of the tagline is an easy process and should not involve significant cost or time. CMS could adapt existing taglines from other agencies or organizations. For example, California has a tagline for use by private health plans and insurers that is available in 13 languages. As another example, the Arizona Department of Economic Security has a "Language Notification Flyer" that states – "If you need this notice translated into your language, please call xxx-xxx-xxxx or xxx-xxx-xxxx." The notice includes 23 languages. HHS could request permission to use these taglines and would merely insert 1-800-MEDICARE in place of the state's numbers. HHS could then translate the tagline into other prevalent languages.[5] This is a small price to pay to ensure language access for LEP enrollees and reduce the burdens on healthcare providers and community based organizations.

Further, having a standardized tagline utilized on all Medicare vital documents utilized by enrollees will assist LEP individuals who may receive multiple documents to recognize the standardized language. It is also important that the tagline be written at a low literacy level so that LEP individuals can understand it. The issue of health literacy is a growing problem in the United States as more than 90 million Americans have low health literacy and this includes many of the LEP individuals as well. So having a standardized tagline written at a low "register" (literacy level) can also assist in comprehension.

ELEMENT 6

We wholeheartedly agree with CMS' recognition of the need for staff training. In addition to the training mentioned, we also suggest that CMS provide training, both during initial training and on an ongoing basis, for CMS' 1-800-MEDICARE customer service staff. This training should include the elements mentioned in Element 6 (civil rights, cultural competency, cultural outreach, cultural sensitivity, ethics of interpreting, and understanding the requirements of the LAP) but also include training on how to effectively work with telephonic interpreters. This type of training is critical to ensuring that customer service staff understands how to access telephonic interpreters, how to manage the flow of a conversation to allow accurate and effective interpreting and are comfortable utilizing the telephonic interpreting services available.

[5] http://www.fns.usda.gov/snap/outreach/translations.htm.

ELEMENT 8

We recognize that resource allocation is a critical feature of providing efficient and cost-effective language services. We are concerned, however, that the report notes that "Bilingual staff, on occasion, [assist] with Medicare beneficiary outreach activities through translation services as necessary". As noted above regarding interpreters, there is a minimal level of knowledge, skills and abilities required to be an effective translator. As the OCR "LEP Guidance" recognizes, just because someone identifies as bilingual does not mean the person can be an effective interpreter. The same applies to translation – just because someone is bilingual does not necessarily mean they have the requisite knowledge (particularly of any technical or specialized terminology), skills and abilities to translate documents.[6] And since the skills and abilities involved are different, an individual who is competent to interpret may not be competent to translate and vice versa. We strongly suggest that if bilingual staff is used to translate, that their competency first be assessed or that translations completed by these individuals are evaluated for accuracy. There are numerous examples of poor translations done by bilingual staff who do not have the requisite abilities.

We suggest that CMS provide explicit guidelines regarding when individuals (staff, caseworkers, etc.) can translate documents. These guidelines should include a language proficiency assessment and training in the knowledge, skills and abilities needed of healthcare translators.

ELEMENT 9

We certainly appreciate CMS' efforts to communicate with stakeholders however we request that more formal efforts be undertaken. We suggest that CMS set up an official stakeholder consultation group comprised of experts in language access (both interpreting and translation services) as well as including representation from LEP communities and their advocates to assist CMS in achieving the goals of its Plan. We also believe there are a number of existing coalitions with whom CMS should formalize outreach activities because of their ongoing work on language access. These coalitions include, at a minimum, the Leadership Conference on Civil and Human Rights (in particular its Health Care Task Force), the language access coalition convened by the National Health Law Program of national stakeholders working on language access issues, and the language access coalition convened by the National Senior Citizens Law Center focusing on Medicare Part D.

Information about CMS' LEP activities should be disseminated widely and also distributed directly through these entities. For example, many advocates learned about the release of this Plan and report not through direct communication from OEOCR but rather indirectly through HHS' Office of External Affairs. And it seemed that many individuals and organizations that had participated on prior stakeholder calls with OEOCR were not on OEA's distribution list and thus received notice of this Plan and opportunity for comment only indirectly

[6] The National Council on Interpreting in Health Care and American Translators Association co-authored an issue brief that outlines the knowledge, skills and abilities required of healthcare interpreters and translators. See *What's in a Word: A Guide to Understanding Interpreting and Translation in Healthcare*, available at http://www.healthlaw.org.

from other sources. With so much at stake, and so much interest from the stakeholder community, we urge CMS and OEOCR to establish more formalized mechanisms, including an ability to register for email alerts from OEOCR on this topic, to ensure greater communication input.

CONCLUSION

We recognize the significant strides CMS has and plans to take to improve language access in its federally conducted activities. We support these efforts and also recommend that CMS examine how it can help improve language access with its federally funded recipients. We look forward to continuing to work with OEOCR and CMS to improve effective communication between the millions of LEP individuals across the country and the healthcare providers who care for them.

If you have any questions about these comments, please contact Mara Youdelman at the National Health Law Program, 202-289-7661 or Youdelman@healthlaw.org.

Sincerely,

National Health Law Program

Alliance for a Just Society
American Hospital Association
Asian American Justice Center, a member of the Asian American Center for Advancing Justice
Asian & Pacific Islander American Health Forum
Asian Pacific American Legal Center
Association of Clinicians for the Underserved
California Family Health Council
California Pan-Ethnic Health Network
California Primary Care Association
Center for Medicare Advocacy
Center for the Elimination of Minority Health Disparities, University at Albany, SUNY
Community Catalyst
Community Legal Services, Inc. (PA)
Community Organizations in Action
Connecticut Multicultural Health Partnership
Disability Rights Education and Defense Fund
Families USA
Florida Legal Services, Inc.
Interpreter Network, LLC (MI)
Latino Health Council of Dane County (Wisconsin)
Massachusetts Law Reform Institute
National Association of Public Hospitals and Health Systems
National Council of Asian Pacific Islander Physicians
National Council of La Raza
National Council on Interpreting in Health Care

National Immigration Law Center
National Partnership for Women & Families
National Senior Citizens Law Center
National Women's Law Center
New Mexico Center on Law and Poverty
New York Immigration Coalition
New York Lawyers for the Public Interest
Northwest Health Law Advocates
Public Justice Center
Racial and Ethnic Health Disparities Coalition
Summit Health Institute for Research and Education, Inc. (SHIRE)
The Leadership Conference on Civil and Human Rights
Virginia Poverty Law Center

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Tasha Richburg, CMS Civil Rights Agency Liaison,
CMS Office of Equal Employment and Civil Rights
Georgina Verdugo, Director, HHS Office for Civil Rights
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