

The ACA and Language Access January 2011

Prepared by: Mara Youdelman

Health care reform offered many opportunities to improve language access by including specific provisions to increase funding, resources, and services. NHeLP convenes a national coalition of stakeholders working on language access issues and this coalition developed a list of principles for health reform that included the overarching principles:

- All limited English proficient patients (LEP) should have access to language services (including oral interpretation and written translations) in all health care and public health settings.
- All health care and public health providers and their staff should have access to competent interpreters and translated materials to ensure effective communication with individuals and families they serve during health services and administrative interactions.

For the full set of principles, see “Principles for Health reform and Language Access”, *available at* <http://www.healthlaw.org>.

While we did gain some improvements in language access in the enactment of the Patient Protection and Affordable Care Act (ACA), many specific issues, particularly around funding, were ultimately not included in the final legislation. This article discusses some of the major provisions addressing language access that were included in the ACA.

General Recommendations

There are a number of provisions in ACA that offer opportunities to specify that language services must be provided or require the provision of certain information in a culturally and linguistically appropriate manner. So what does this mean in practice? A lot is left to the Administration to determine as part of ACA implementation. But that offers many opportunities to influence implementation and improve language services.

So first are some basic recommendations with regards to language access. Language services – including oral interpreting and written translation¹ – should be required in all new demonstration programs, payment systems, and models enacted as part of the ACA. This should include plans participating in the new health insurance Exchanges.

¹ For more information on the differences between interpreting and translation, see NCIHC, ATA & NHeLP, “What’s in a Word: A Guide to Understanding Interpreting and Translation in Health Care,” *available at* http://www.healthlaw.org/images/stories/Whats_in_a_Word_Guide.pdf.

With regard to oral communication, LEP individuals should be able to access bilingual staff or interpreters to assist with oral communication at all points of contact with the health care system – from registration/intake and clinical encounters to financial counseling and customer service. When an LEP individual needs oral language services to communicate with health care providers or other participants in the health care system in a way that provides meaningful access, interpreters or bilingual staff should be provided.

With regard to written materials, information should be translated into multiple languages and “taglines” should be included on notices to alert LEP individuals of the importance of a particular document. When information is unavailable in an individual’s language, an LEP individual should be able to obtain information orally.

The needs of LEP individuals must be considered as regulations, policies, procedures, and websites are being developed and implemented. This should apply whether the information is provided by federal or state governments, or plans participating in the Exchange.

The question arises as to how many languages materials should be translated into. The Department of Health and Human Services’ Office for Civil Rights LEP Guidance (available at www.lep.gov) outlines guidelines for translating materials for entities that receive federal funds. These state that “vital” documents should be translated for each LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered. Translation of other documents, if needed, can be provided orally via a process called “sight translation.”² In addition, the Guidance states that if there are fewer than 50 persons in a language group that reaches the five percent trigger above, the recipient does not need to translate vital written materials but can provide written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials, free of cost.

These guidelines apply to the translation of written documents only. They do not affect the requirement to provide meaningful access to LEP individuals through competent oral interpreters where oral language services are needed.

Notably, the Social Security Administration (SSA) regularly translates materials into 15 languages. We believe HHS should use this as a guide and translate its documents that are used by beneficiaries into at least 15 languages. This is particularly effective when documents are standardized at the federal level because of the cost efficiencies of HHS translating materials rather than individual health care providers or various plans/insurers translating the documents.

² Sight translation is when an interpreter is given a document in one language (e.g. English) and orally communicates it in the patient’s language (e.g. Spanish). Sight translation should not be utilized for long or complex documents. For more information on sight translation, see “Sight Translation and Written Translation: Guidelines for Healthcare Interpreters”, available at <http://data.memberclicks.com/site/ncihc/Translation%20Guidelines%20for%20Interpreters%20REVISED%2031710.pdf>.

In addition to translating certain documents into multiple languages, we recommend that all entities subject to the ACA – HHS itself as well as the health insurers/plans that will be providing services through the new Exchanges – ensure that vital documents include a “tagline” in at least 15 languages (at the top of the notice or as a prominent insert in the same mailing) that informs recipients that the notice is important and how to obtain information about the document in the individual’s language. For example, private health plans that serve California – and thus approximately 12% of the nation’s population – are already required to provide such notice. As an example, California’s Department of Managed Healthcare offers a sample language access notice with taglines in 12 languages.³ The tagline states:

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to ask about written information in (your language), first call your health plan’s phone number at 1-XXX-XXX-XXXX. Someone who speaks (your language) can help you. If you need more help, call the HMO Help Center at xxx-xxx-xxxx.

Finally, we also recommend that organizations or agencies using an automated telephonic system be required to add voice prompts in multiple languages. Currently, many voice prompts are only available in English and, if any additional language, Spanish. Voice prompts should be added for frequently encountered languages so that LEP individuals can quickly access competent bilingual customer service representatives or English-speaking representatives who communicate with LEP individuals using interpreters. Further, HHS should ensure that the staff providing information is trained to respond appropriately to LEP callers and how to access bilingual staff or interpreters.

The remainder of this memo discusses specific provisions of the Affordable Care Act that support the provision of language services.

Nondiscrimination, ACA § 1557⁴

This provision extends the application of Title VI (among other existing federal civil rights laws) prohibiting discrimination on the basis of race, color or national origin to:

- any health program or activity receiving federal financial assistance;
- any program or activity administered by an executive agency; or
- any entity established under Title 1 of ACA (e.g. Exchanges).

Any program, activity or entity described above cannot discriminate on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.). The provision prohibits any individual from being excluded from participation in, denied the benefits of, or

³ <http://www.hmohelp.ca.gov/library/reports/news/snla.pdf>.

⁴ For more information on the application of § 1557 and Title VI of the Civil Rights Act of 1964 to Exchanges, see NHeLP’s Issue Brief “The Application of PPACA § 1557 and Title VI of the Civil Rights Act of 1964 to the Health Insurance Exchanges”, available at <http://www.healthlaw.org>.

subjected to discrimination under, any health program or activity, any part of which is receiving federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). This provision extends the protections to “contracts of insurance,” which generally have been exempted from civil rights protections.

Further, the provision allows the use of the same enforcement mechanisms provided for and available under Title VI (or the other civil rights statutes also referred to in the provision). Thus, victims of intentional discrimination will be able to bring cases in court, and the Department of Health and Human Services will have the enforcement authority to act on both individual complaints and initiate its own investigations of both intentional and disparate impact discrimination. If state law offers greater protections to employees than those provided under this section, the state law is not overridden by this provision.

HHS has designated the Office for Civil Rights to issue regulations, a process currently underway. Given the application of this provision to any entity created by Title I, it has broad reach into the private insurance market as Title I creates the state Exchanges which will designate qualified health plans to participate.

Recommendation: We recommend that the regulations clarify the scope and reach of this provision and ensure that it is broadly applied not only to the state Exchanges but also to all grant and demonstration programs funded through the ACA and through HHS generally which receive federal financial assistance.

Requirements for Notices, ACA § 1001 (PHSA § 2719)

A group health plan and a health insurance issuer offering group or individual health insurance coverage must implement an effective appeals process for appeals of coverage determinations and claims. At a minimum, the plan/issuer must provide notice to enrollees, ***in a culturally and linguistically appropriate manner***, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombuds established by ACA § 1002 creating new Public Health Service Act (PHSA) § 2793 to assist such enrollees with the appeals processes. (See new PHSA § 2719, added by ACA § 1001.)

The Departments of Health and Human Services, Labor and Treasury issued interim final rules implementing this provision. Under these regulations, small plans (those with under 100 enrollees) would require translation of notices if 25% or more enrollees are literate only in the same non-English language. For all other plans, the rule requires that notices be translated in instances where the lesser of 500 enrollees or 10% of all enrollees speak the same language. For NHeLP’s comments suggesting clarifications to these thresholds and additional requirements for the interim final rule, see http://www.healthlaw.org/index.php?option=com_content&view=article&id=501%3Ahealth-reform-nhelp-comments&catid=51&Itemid=212.

Recommendation: Plans should be required to translate notices into multiple languages and include taglines, as discussed above under “General Recommendations”.

“Plain Language” Requirement, ACA § 1331

The ACA Exchange provisions require health plans seeking certification as qualified health plans (only qualified health plans may participate in an Exchange) to submit to the Exchange, the Secretary of HHS, the state insurance commissioner, and make available to the public, accurate and timely disclosure of:

- claims payment policies and practices;
- periodic financial disclosures;
- data on enrollment and disenrollment;
- data on the number of claims that are denied;
- data on rating practices;
- information on cost-sharing and payments with respect to any out-of-network coverage;
- information on enrollee and participant rights; and
- any information as determined appropriate by the Secretary.

Most importantly, the information must be provided in “plain language” defined to mean “language that the intended audience, *including individuals with limited English proficiency*, can readily understand and use because that language is concise, well organized, and follows other best practices of plain language writing.” See ACA § 1311 (emphasis added). The Secretaries of HHS and Labor must jointly develop and issue guidance on best practices of plain language writing.

Recommendations: We recommend that implementation of this provision require plans to ensure that the information is provided at a low literacy level and then translated into multiple languages. The information should also include taglines, as outlined above under General Recommendations. If the information is not readily available in an individual’s language, we believe that HHS should require plans to provide alternative means of obtaining the information such as via oral communication using bilingual staff or interpreters.

Summary of Coverage and Benefits, ACA § 1001 (PHSA §2715)

HHS must develop standards (for group health plans and health insurance issuers offering group or individual health coverage) for a summary of benefits and coverage explanation that must be provided to applicants, enrollees, and policy/certificate holders. Among other requirements, the standards must be in language that is *culturally and linguistically appropriate*, and will be understood by the “average plan enrollee.” See ACA § 1001 (emphasis added).

The purpose of this provision is, in part, to allow consumer understanding and comparison between plans and the summary will include a description of the coverage, including cost-sharing and information on: exceptions, reductions and limitations on coverage; cost-

sharing, including deductibles, co-insurance and co-payments; and provisions related to renewability and continuation of coverage.

Recommendation: We recommend that the summary be translated into multiple languages and include taglines. Alternative means of communicating the information in the summary should be required for individuals for whom translated information is unavailable.

Quality Incentives, ACA § 1311

Section 1311 describes a payment structure for Exchange plans that provides increased reimbursement or other incentives to reward quality through market-based incentives for, among other factors, the implementation of activities to reduce health and health care disparities, including through *the use of language services*, community outreach and *cultural competency trainings*.

The Secretary, in consultation with experts in health care quality and stakeholders, must develop guidelines for these strategies. And plans must periodically report their activities to implement these strategies to the Exchange. It seems the intent is for the public reporting to incentivize plans to possibly offer higher reimbursement or other incentives to participating providers. There is no funding attached or explicit requirement to undertake these strategies, only to report what has been done.

Recommendation: We recommend that any incentives be predicated on plans paying for and providing language services to ensure access for LEP enrollees at all points of contact with the plan.

Exchanges⁵

In August 2010, HHS' Office of Consumer Information and Insurance Oversight (OCIIO) issued a request for comment Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act on the Exchanges. NHeLP submitted extensive comments on language access issues that should be considered in both the development of the Exchanges themselves as well as for plans participating in the Exchanges. These can be found at http://www.healthlaw.org/index.php?option=com_content&view=article&id=501%3Ahealth-reform-nhelp-comments&catid=51&Itemid=212.

Recommendation: Language services should be required for both the Exchanges themselves and for plans participating in the Exchanges. When OCIIO issues regulations governing the Exchange-Related Provisions, organizations should evaluate these regulations and consider submitting comments related to language access issues.

Patient Navigators, ACA § 1311

⁵ For more information on the application of § 1557 and Title VI of the Civil Rights Act of 1964 to Exchanges, see NHeLP's Issue Brief "The Application of PPACA § 1557 and Title VI of the Civil Rights Act of 1964 to the Health Insurance Exchanges", available at www.healthlaw.org.

The ACA authorizes funding to establish patient navigators to provide fair, accurate and impartial information and other activities. The Secretary of HHS must establish standards for navigators, who may not be a health insurance issuer, or receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan. (ACA § 1311). Navigators must provide information in a manner that is *culturally and linguistically appropriate* to the needs of the population being served by the Exchange or Exchanges.

Recommendations: Include explicit requirements for entities serving as navigators to provide language services including translating materials and offering interpreters. Allow grantees to include the costs of providing languages services in their funding requests.

Data Collection, ACA § 4302 (PHSA §3101)

This provision addresses a number of deficiencies in federal data collection needed to identify health disparities. First, within two years of the date of enactment, HHS must collect and report data in any federally conducted or supported health care or public health program, activity or survey (including Current Population Surveys and American Community Surveys conducted by the Bureau of Labor Statistics and the Bureau of the Census). Second, HHS must require that any reporting requirement imposed for quality measurement under any ongoing or federally conducted or supported health care or public health program, activity, or survey include requirements for the collection of data on individuals receiving health care items or services.

The data collected includes language data and HHS must develop standards for collecting language data. See PHSA § 3101(a)(2)(C). These standards must require, at a minimum, self-reported data by the applicant, recipient, or participant and collection of data from a parent or legal guardian if the applicant, recipient, or participant is a minor or legally incapacitated.

HHS, through the National Coordinator for Health Information Technology, is also tasked with developing national standards for the management of data collected and interoperability and security systems for data management. HHS must analyze this data to detect and monitor trends in health disparities at the federal and state levels.

This provision also amends the Children’s Health Insurance Program statute to require the collection of language data of enrollees and, for enrollees who are under 19, the language of the enrollee’s parent or guardian. See PHSA § 3101(b)(1)(B) amending 42 U.S.C. § 1397hh(e)).

Unfortunately, this provision includes a subsection precluding its implementation without funding. This may significantly limit the collection of this data, much of which could be undertaken under current authority without needing financial appropriations. NHeLP is working with other organizations to obtain funding to implement this provision.

Recommendations: We recommend that HHS work to improve its data collection using its existing authority and support efforts to appropriate additional funds to expand data collection.

We also recommend that HHS adopt the standards for collecting language data issued by the Institutes of Medicine.

Other Payment Systems and Demonstration Programs

There are a number of provisions creating new demonstration programs or testing new payment systems including Accountable Care Organizations (ACOs) and medical homes.

Some of these demonstration programs are testing new quality measures. It is critical that the design of these programs not disfavor the inclusion of particular groups of patients, such as LEP patients, for whom there may be greater costs due to the need to provide language services. By including funding for language services and explicitly requiring the provision of language services, we can evaluate the effectiveness of these programs for LEP populations as a subgroup of the wider population receiving care.

Many of these new programs pay providers a fixed “bundled” payment for the patients they treat. These bundled payments may cover all the costs of covered care rather than a provider billing for each item or service provided. Bundling offers the opportunity to adequately account for comprehensive costs of health care – including language services – within one payment rate. This could enhance comprehensive, coordinated care. On the other hand, bundling could create incentive problems and concerns. First, inadequately funded providers may have an incentive to deny care or language services because every service provided is a cost drawn from the flat fee the provider received. A bundled payment that does not adequately compensate for the costs of language services could discourage providers from treating LEP patients or paying for language services for participating LEP patients. Or it could discriminate against providers who have high LEP patient populations who would have to spend a greater amount of a bundled payment on language services than providers with few LEP patients, leaving these providers with a more limited ability to reduce overall costs or improve quality. Because the bundled payment is a set amount, if a provider has to hire an interpreter or translate materials, the cost may exceed a standard bundled payment if the standard is created for non-LEP patients.

While it is likely that entities funded through these programs would be subject to Title VI and the nondiscrimination provision (see above) to provide language services, we believe there should be explicit requirements in the request for proposals and grant contracts of these programs to:

- provide language services;
- pay for language services by including funding allowances in budgets;
- collect and report data on participants’ language needs and use of language services; and
- stratify results by LEP/non-LEP or language subgroups (when sufficient numbers exist) to identify any discrepancies in outcomes based on language needs.

Recommendations: We recommend that when bundled payments are utilized, HHS adopt either an adjustment (called a “risk adjustment”) that pays a higher bundled payment for LEP patients

to cover the costs of language services or provides a separate payment or budget allocated specifically for language services. This will recognize that an LEP patient may cost more to treat not because of a clinical condition but because of the costs of providing effective language services.

Some of the provisions to which these concerns apply include:

- Providing Federal Coverage and Payment Coordination to Dual Eligible Beneficiaries, ACA § 2602
- State Option to Provide Health Homes for Enrollees with Chronic Conditions , ACA § 2703
- Demonstration Project to Evaluate Integrated Care Around a Hospitalization, ACA § 2704
- Medicaid Global Payment System Demonstration Project, ACA § 2705
- Pediatric Accountable Care Organization Demonstration Project, ACA § 2706
- Medicaid Emergency Psychiatric Demonstration Project, ACA § 2707
- MACPAC Assessment of Policies Affecting all Medicaid Beneficiaries, ACA § 2801
- Establishment of Center for Medicare and Medicaid Innovation (“CMI”) Within CMS, ACA §§ 3021
- Medicare Shared Savings Program, ACA §§ 3022
- National Pilot Program on Payment Bundling, ACA §§ 3023
- Independence at Home Demonstration Program, ACA § 3024
- Community Based Care Transition Programs, ACA § 3026
- Independent Payment Advisory Board, ACA §§ 3403

Workforce and Prevention, ACA Title V

As with many of the sections addressed above, there are numerous references to the need to provide culturally and linguistically appropriate training or services in the workforce and prevention provisions of ACA. Advocates should be vigilant to ensure these provisions result in practical improvements and not mere formalities for a grant application.

Training Programs, ACA §§ 5002, 5303, 5306, 5507

Title V of the ACA addresses workforce issues. In the definitions section, the Secretary is required to develop a definition for the term “cultural competency.” See ACA § 5002(a)(15).

In addition, funding is authorized for two new training programs which include a priority for applicants who provide ***training in cultural competency*** (which should include information about language services). These programs will train individuals for:

- family medicine, general internal medicine, or general pediatrics for medical students, interns, residents, or practicing physicians (ACA § 5301, enacting PHSA § 747); and

- general dentistry, pediatric dentistry, or public health dentistry for dental students, residents, practicing dentists, dental hygienists, or other approved primary care dental trainees, that emphasizes training for general, pediatric, or public health dentistry (ACA § 5303, enacting new PHSA § 748);

Another provision authorizes loan repayment for individuals employed in a pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including substance abuse prevention and treatment services. There is a priority for individuals who have familiarity with *training in cultural competency* (ACA § 5203, enacting PHSA § 775).

Mental and behavioral health education and training grants require applicants to demonstrate participation of individuals and groups from different racial, ethnic, *cultural, and linguistic backgrounds* (ACA § 5306, enacting PHSA § 776). Further, any internship or other field placement program assisted under the grant must prioritize cultural and linguistic competency.

In funding to train personal or home care aides, the core training competencies must include *cultural and linguistic competence and sensitivity*. (ACA § 5507, enacting new Social Security Act § 2008).

Community Health Workers and Health Extension Agents, ACA §§ 5313, 5405

New grants to promote the use of community health workers, the definition of a “community health worker” is one who provides *culturally and linguistically appropriate health or nutrition education*. (ACA § 5313, enacting PHSA § 399V.) A grant to establish a primary care extension program defines a ‘Health Extension Agent’ as a local or community-based health worker who facilitates and provides assistance to primary care practices by implementing quality improvement or system redesign, incorporating the principles of the patient-centered medical home to provide high-quality, effective, efficient, and safe primary care and *to provide guidance to patients in culturally and linguistically appropriate ways*, and linking practices to diverse health system resources. (ACA § 5405, enacting PHSA § 399W.)

Cultural Competency Curriculum, ACA § 5307

The ACA also requires development of model *cultural competency curriculum*. As language access issues are a part of cultural competency, we recommend that this training include information about treating LEP patients such as providing language services and working and with interpreters. The Secretary of HHS must evaluate the adoption and the implementation of cultural competency training curricula and facilitate inclusion of these competency measures in quality measurement systems as appropriate.

Conclusion

The gains achieved in enactment of the ACA offer real opportunities for improving access to and quality of care for LEP individuals. The devil will be in the details of implementation, and it is imperative that implementation build on the requirements included in ACA and existing law to improve language access in a meaningful and systematic way. To ensure effective communication and ensure truly patient-centered care, the language a patient speaks must not impede the patient's ability to access the myriad of new opportunities for coverage, access and care offered by health care reform.

For further information, please contact:

Mara Youdelman

youdelman@healthlaw.org

www.healthlaw.org