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*National Advocates for Asian American, Native Hawaiian & Pacific Islander Health*

March 31, 2011

Donald M. Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Washington, DC 20201

Re: *Comments on FY 10 CMS Strategic Language Access Plan (LAP) Outcome Report*

Dear Dr. Berwick:

The Asian & Pacific Islander American Health Forum (APIAHF) and the undersigned organizations thank the Centers for Medicare and Medicaid Services (CMS) at the Department of Health and Human Services (HHS) for the opportunity to comment on the draft FY 10 CMS Strategic Language Access Plan (LAP) Outcome Report. We strongly support the efforts of CMS in seeking to ensure CMS priorities and programs are accessible for limited English proficient (LEP) populations, such as Asian Americans, Native Hawaiians, and Pacific Islanders.

Asian American and Pacific Islander communities are overwhelming immigrant; over 60 percent of Asian Americans and 30 percent of Pacific Islanders living in the U.S. are foreign-born, representing the full spectrum of immigration status categories. Asian Americans, Native Hawaiians, and Pacific Islanders trace their heritage to more than 50 countries and speak more than 100 different languages. Data from the U.S. Census Bureau's American Community Survey reveal that more than 8 million people in the United States speak Asian and Pacific Island languages at home and more than 4 million of them are considered "limited English proficient," meaning they speak English less than "very well" or not at all.[i]

Language barriers affect the integration and participation of Asian Americans, Native Hawaiians, and Pacific Islanders in federal programs. For limited English proficient (LEP) patients in particular, the inability to communicate can directly impact their access to and quality of care. For example, high LEP populations are less likely to receive preventive care and physician counseling.[ii]

For these reasons, we strongly support the development of the LAP Outcome Report and its emphasis on reducing language and cultural barriers experienced by Asian Americans, Native Hawaiians, and Pacific Islanders. We are very pleased with the Phase Two plans to translate 160 Medicare vital documents into 15 additional languages. Moreover, we commend CMS' renewed emphasis on ensuring compliance with Title VI of the Civil Rights Act of 1964 and Executive Order 13166. This aligns with the memo the Attorney General recently released, *Federal Government's Renewed Commitment to Language Access Obligations Under Executive Order 13166*, reaffirming the Administration's commitment to providing effective language services.

In an effort to strengthen the LAP and ensure successful implementation, we urge CMS to consider the following modifications and additions to the report:

**Element 1—Assessment: Needs and Capacity**

Collect and Disaggregate Race, Ethnicity and Primary Language Data: In addition to gathering data on the number and/or proportion of LEP persons in the populations served, we recommend CMS collect and report disaggregated race and ethnicity data. We urge CMS to adopt the recommendations from the 2009 Institute of Medicine (IOM) Report[iii] on race, ethnicity and language data (*Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*) as a guide for disaggregating such data.[iv] Moreover, as required by the Patient Protection and Affordable Care Act (PPACA) Section 4302, we recommend CMS collect primary language data for all Medicare enrollees, in addition to those using the 1-800-MEDICARE Help Line. Primary language data is essential to assessing language need and capacity.

Revise the Threshold for Determining Translation and Interpretation Service Need: We disagree with CMS' adoption of a "10 percent of the service area population" threshold. The 10 percent threshold shuts out most LEP beneficiaries from the right to receive documents that they can use and understand, is inconsistent with Title VI of the Civil Rights Act, and is out of step with other HHS regulations including HHS Title VI guidance, DOJ Title VI guidance and the Title VI guidance of other agencies.

The HHS Office of Civil Rights (OCR) sets a standard in its Title VI LEP Guidance for written materials at "5 percent or 1,000 individuals, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered."[v] We suggest combining the 5% threshold from HHS with a lower number that is used by the Department of Labor in regulations governing large health plans—500 or 1,000. In short, we encourage CMS to adopt a "5 percent or 500 individuals in a particular language group" threshold. Since CMS as an entity is larger than any large insurance plan, we believe that it should be held 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.

For oral interpretation services, we do not believe that there should be any threshold as recognized by OCR' LEP Guidance.

**Element 2—Oral Language Assistance Services**

Expand the Number of Front-line Languages: CMS should expand the number of front-line languages beyond English and Spanish for the 1-800-MEDICARE Help Line, Medicare Prescription Drug and Health Plans, and other CMS contractors.

Improve Help Line Infrastructure: While we commend the availability of 150 languages through the 1-800-MEDICARE Help Line, the current Help Line is difficult to maneuver for LEP persons seeking an interpreter (other than Spanish). We urge CMS to take steps to improve the Help Line to make it more user-friendly and accessible to LEP persons. As part of this effort, we recommend CMS consult with relevant stakeholders, including AA and NHPI community based organizations.

Include Community Health Workers when Translation Services are Required: While the use of interpreters is often a sound strategy, we propose that CMS provide funding to employ Community Health Workers (CHWs) when translation services are required. CHWs, such as those utilized by community health centers, often have key relationships and established rapport with patients. CHWs are typically members of the communities in which patients reside, and by working with providers they have been instrumental in persuading patients to utilize preventive health care services. Community health workers, also known as community health advocates and community health outreach workers, have been shown in studies to be a trusted source among patients. These same studies found that patients are often at ease and comfortable contacting a CHW on health-related issues. Not only are CHWs an effective means of reaching out to patients, they are also cost effective as they encourage patients to consistently access preventive care services, which deters this patient population from relying on more costly emergency room services.

**Element 3—Written Translations**

Revise the Threshold for Determining Translation Need: As mentioned, we disagree with the 10 percent threshold for translating written documents and recommend adoption of a combined 5 percent threshold from HHS and 500 individuals from DOL.

Integrate Translated Taglines in all Vital Documents: We support CMS' plans to translate vital documents into 15 languages in addition to Spanish and English. However, given that the translation process will take three years, we suggest CMS begin using "taglines" in at least 15 languages on all of the vital documents on an interim basis. Having a standardized tagline in all Medicare vital documents will help LEP individuals begin to recognize the standardized language.

Ensure Materials are Translated at Appropriate Health Literacy Levels: Differences in education levels and health literacy can have an impact on an individual's reading comprehension. We recommend CMS translate documents to an eighth grade or lower reading level and avoid the use of health care jargon and idioms.

Develop an Outreach Strategy to Disseminate Translated Vital Documents: To ensure broad accessibility and use of CMS' translated documents, we recommend CMS conduct targeted outreach to high LEP populations, through a variety of media outlets, including ethnic media, to increase awareness of translated materials.

**Element 4—Policies and Procedures**

Ensure Community Stakeholder Consultation: We urge CMS to involve diverse stakeholder groups, including Asian American, Native Hawaiian, and Pacific Islander communities, in formulating agency-wide language access policies.

**Element 5—Notification of the Availability of Free Language Services**

Create a Targeted Outreach Strategy for High LEP Populations: In developing the Language Access Notification plan, CMS should create targeted outreach campaigns for high LEP populations. For example, CMS should include taglines on vital

documents, in multiple languages, instructing LEP persons of the availability of interpretation and translation. In addition we recommend CMS:[vi]

- Identify key consumer groups by language, literacy, disability, culture, health conditions, and other factors.
- Involve low health literacy groups in the development of outreach strategies.
- Apply proven health literacy design principles derived from usability testing.
- Adhere to tested health literacy and communication standards.
- Develop tracking and evaluative tools for the improvement of outreach strategies.

**Element 6—Staff Training**

Increase Workforce Diversity: We strongly support frequent training for front-line and supervisory CMS staff on cultural competency and language access issues and polices. In addition, consistent with Attorney General Holder's February 17, 2011 memorandum to federal agencies on Obligations Under Executive Order 13166, we recommend CMS recruit a more diverse workforce with the technical, cultural, and linguistic expertise required to serve high LEP populations.

Establish Standards for Bilingual Staff and Insure Bilingual Staff are Trained: Translation and interpretation require specific knowledge and skills, which bilingual staff may or may not have. We strongly urge CMS to develop specific guidelines specifying when and under what conditions bilingual staff may provide language services. In addition, we recommend CMS develop standards and trainings for bilingual staff to ensure consistent and accurate interpretation and translation.

**Element 7—Assessing Accessibility and Quality**

Improve Quality Standards: In regards to Medicare Prescription Drug and Health Plans quality monitoring, we recommend revising the definition of "adequate access to oral language services." The current definition of adequate access, defined as a caller being connected to an interpreter on the first attempt more than 50 percent of the time, is insufficient. The current definition undermines CMS' strive for quality as more difficult cases can be dropped and mistakes speed for quality of customer service. We urge CMS to develop a patient-centered model that emphasizes caller satisfaction and outcomes.

Improve Transparency: We urge CMS to make the established measurements for quality monitoring of language access services publicly available, including listing these measurements in the FY 10 Outcomes Report. Moreover, we recommend CMS develop a strategy for ensuring compliance if quality standards are not met.

**Element 8—Resource Utilization**

Expand Resources for Outreach: We appreciate the range of activities CMS participates in to improve language access infrastructure and outreach. In addition, we suggest that CMS develop and implement large-scale community-targeted outreach strategies, such as public outreach campaigns that utilize ethnic media, to improve knowledge and awareness of CMS programs and services in non-English communities.

**Element 9—Stakeholder Consultation**

Consult AA and NHPI Stakeholder Groups and Community-based Organizations: We appreciate CMS' efforts to engage with stakeholders and recommend CMS ensure AA and NHPI stakeholder groups are informed and included as consultants in all aspects of the LAP, including the development and execution of targeted campaigns and partnerships to reach high LEP populations and development of an agency-wide emergency preparedness plan for language access services. AA and NHPI stakeholder groups are active participants in a number of existing coalitions including the National Council of Asian Pacific Americans' Health Committee, the Language Access Coalition convened by the National Health Law Program, and the Leadership Conference on Civil and Human Rights' Health Care Task Force.

**Element 11—Information Technology**

Expand the Number of Languages Medicare.gov is Translated into: We strongly urge CMS to translate Medicare.gov and its major tools into additional languages beyond Spanish to ensure meaningful access to language services for LEP populations.

**Additional Recommendations:**

In addition, we strongly urge CMS to consider the following recommendations to enhance the FY 10 LAP Outcome Report.

Align the LAP Outcome Report with the Patient Protection and Affordable Care Act

The LAP Outcome Report should align and bolster the reform objectives of the Patient Protection and Affordable Care Act (PPACA). Health care reform offers many funding, service and programmatic opportunities to improve language access. For example, PPACA emphasizes quality improvement through patient-centered care delivery models and reductions in health and health care disparities through expanded coverage and access. PPACA supports patient-centeredness by requiring the Secretary of HHS develop and annually update a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes and population health. CMS should align the LAP Outcome Report with the PPACA by focusing on patient-centered care across the plan. For example, CMS' Interim Final Rule for "meaningful use" of electronic health records (EHRs) provide a guide for this alignment.

In addition, PPACA reinforces many of the civil rights protections that are needed to achieve health equity. For example, PPACA requires any health care activity or program receiving federal financial assistance, credits, subsidies or contract of insurance to comply with the nondiscrimination provisions of Section 1557, which forbids discrimination on the grounds of race, color, national origin, gender, age, or disability. Health care plans, programs and organizations covered under Section 1557 must provide equitable services and benefits that are accessible to all groups, including individuals with limited English proficiency.

Finally, with HHS and most states deep in the planning stages of setting up their

health insurance exchanges, it is critical to ensure that the "plain language" requirements in the exchange provisions (PPACA § 1311), summary of coverage and benefits requirements (PPACA § 1001), patient navigator grant requirements (PPACA § 1311) and other provisions are implemented in a way that requires plans and grantees to provide multilingual language access services and written translations. We hope that CMS' Strategic Language Access Plan can serve as a guide for CMS' Center for Consumer Information and Insurance Oversight (CCIIO), states and other governmental entities to promulgate regulations and adopt policies that meet the diverse language access needs of our communities.

**Conclusion**

In conclusion, APIAHF and the undersigned organizations appreciate the opportunity to comment on the draft FY 10 CMS Strategic Language Access Plan (LAP) Outcome Report and CMS' commitment to meaningfully include Asian Americans, Native Hawaiians, and Pacific Islanders within the federal government. Please contact Priscilla Huang, Associate Policy Director for the Asian & Pacific Islander American Health Forum at phuang@apiahf.org with any questions or additional information. We welcome future opportunities to work together on behalf of our communities.

Respectfully,

Asian & Pacific Islander American Health Forum (San Francisco, CA and Washington DC),

and

AlohaCare (Honolulu, HI)
Asian Americans for Community Involvement (San Jose, CA)
Asian Health Services (Oakland, CA)
Asian Human Services (Chicago, IL)
Asian Pacific Health Care Venture (Los Angeles, CA)
Asian Services In Action (Cleveland, OH)
Association of Asian Pacific Community Health Organizations (Oakland, CA)
Bay Clinic, Inc. (Hilo, HI)
Charles B. Wang Community Health Center (New York, NY)
Chinatown Service Center Community Health Center (Los Angeles, CA)
Coalition for Asian American Children and Families (New York, NY)
Community-University Health Care Center (Minneapolis, MN)
Family Health Center of Worcester (Worcester, MA)
Family Health Project, Inc. (New York, NY)
International Community Health Services (Seattle, WA)
Japanese American Citizens League (Washington DC)
Kalihi-Palama Health Center (Honolulu, HI)
Kokua Kalihi Valley Comprehensive Family Services (Honolulu, HI)
Ko'olauloa Community Health & Wellness Center (Kahuku, HI)
Kwajalein Atoll Community Health Center (Ebeye, MH)
Lanai Community Health Center (Lanai City, HI)
Lowell Community Health Center (Lowell, MA)
MQVN Community Development Corporation (New Orleans, LA)

National Alliance to Nurture the Aged and the Youth (North Miami, FL)
National Asian Pacific American Women's Forum (Washington DC)
National Tongan American Society (Salt Lake City, UT)
Neighborcare Health (Seattle, WA)
North East Medical Services (San Francisco, CA)
OCA (Washington DC)
Operation Samahan Health Clinic (National City, CA)
Pacific Islands Primary Care Association (Honolulu, HI)
Papa Ola Lokahi (Honolulu, HI)
PTSO of Washington (Seattle, WA)
Samoan National Nurses Association (Long Beach, CA)
South Asian Americans Leading Together (Takoma Park, MD)
South Cove Community Health Center (Boston, MA)
Waianae Coast Comprehensive Health Center (Waianae, HI)
Waimanalo Health Center (Waimanalo, HI)
West Hawaii Community Health Center (Kailua Kona, HI)

Cc: Howard K. Koh, MD, MPH, Assistant Secretary for Health, DHHS
Garth Graham, MD, MPH, Deputy Assistant Secretary for Minority Health, OMH
Kiran Ahuja, JD, Executive Director, White House Initiative on Asian Americans and Pacific Islanders

[i] "2001 Health Care Quality Survey," The Commonwealth Fund, November 2001. Available at http://www.commonwealthfund.org/Content/Surveys/2001/2001-Health-Care-Quality-Survey.aspx.
[ii] Id.
[iii] Id.
[iv] The report highlighted the need for granular ethnicity data, and recommended that the Department of Health and Human Services develop and make available nationally standardized lists for granular ethnicity categories, and proposed strategies for aggregating granular ethnicity categories to the broader OMB race and Hispanic ethnicity categories. Specifically, the IOM Report proposed the following order of questioning in the collection of race and ethnicity data: Hispanic ethnicity first, followed by OMB race categories, and then granular ethnicity. The granular ethnicity categories should be locally relevant response categories selected from a national standard list with appropriate coding, such as the Centers for Disease Control and Prevention (CDC)/Health Level 7 (HL7) Race and Ethnicity Code Set 1.0. In addition, an open-ended option of "Other, please specify: __" should be provided for persons whose granular ethnicity is not listed as a response option.
[v] "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," U.S. Department of Health and Human Services. Available at http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html.
[vi] "National Plan to Improve Health Literacy," U.S. Department of Health and Human Services, June 2010. Available at http://www.health.gov/communication/hlactionplan/