APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

July 21, 2011

Dr. Donald M. Berwick
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244

Re: Group Health Plans and Health Insurance Issuers: Internal Claims and Appeals and External Review Processes

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

Dear Dr. Berwick:

The Asian & Pacific Islander American Health Forum (APIAHF) thanks the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the Group Health Plans and Health Insurance Issuers: Internal Claims and Appeals and External Review Processes. These comments are limited to the proposed regulations addressing the threshold for translation and oral interpretation of private plan materials in the internal review and appeals contexts. While we applaud CMS' recent efforts to ensure CMS priorities and programs are accessible for limited English proficient (LEP) populations, we caution CMS against adopting the proposed 10 percent threshold for written translations and oral interpretation.

For almost 25 years, APIAHF has dedicated itself to improving the health and well-being of Asian American, Native Hawaiian, and Pacific Islander communities (AA and NHPI). Asian American and Pacific Islander communities are overwhelmingly 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 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.[1]

Language barriers are widely known to reduce rates in enrollment and lower the quality and effectiveness of prevention, treatment and patient education programs. Poor communication between providers and patients can also lead to medical errors that are dangerous to patients and cost the U.S. health care system more than $69 billion every year. As such, many hospitals, health plans, and private physician offices have voluntarily adopted language access practices in an effort to increase patient safety and improve quality.[2]

[1] "Language Use in the United States: 2007," U.S. Census Bureau, American Community Survey Reports, April 2010. Available at http://www.census.gov/prod/2010pubs/acs-12.pdf.
[2] *See* The Joint Commission, "Hospitals, Language, and Culture: A Snapshot of the Nation," 2007. Available at http://www.jointcommission.org/assets/1/6/hlc_paper.pdf.

The interim final rule sets a 10 percent threshold for written translations for group and individual health plans, requiring these plans to translate written materials (in the internal claims and appeals context) only into languages spoken by 10 percent or more of the population residing in the claimant's county. Under this standard, most of the approximately 3 million LEP Medicare enrollees would not have written materials in their plans translated into their languages. In addition, the focus on percentage of the population does not take into account the disproportionate language assistance needs of a population. For example, California's federal district 9 (encompassing a portion of Alameda county) is 8 percent Chinese, however 51 percent are LEP.[3] Moreover, the 10 percent threshold is so high that even Spanish speakers would be left without translated materials as only about 172 counties, out of the over three thousand in the United States, would meet the threshold. Similarly, only one county would meet the threshold for Chinese.

The 10 percent threshold shuts out most LEP beneficiaries from the right to receive documents that they can use and understand. While many LEP persons may receive marketing materials in their primary languages, under the current 5 percent CMS threshold, they would be unable to review their claims and appeals under the new standard. Moreover, the proposal is inconsistent with Title VI of the Civil Rights Act and out of step with other HHS regulations including HHS Title VI guidance, DOJ Title VI guidance and the Title VI guidance of other agencies. CMS should abandon the proposed threshold and adopt regulations that support the purpose of Title VI.

Therefore, we urge CMS to substitute the proposed threshold with the following recommendation by the National Senior Citizens Law Center and the National Health Law Program:

> Large group plans must provide translated marketing materials in any language that is spoken by more than "**5% of the population in a plan service, or 500 members if the plan, whichever is lower.**" Small group plans can continue at the 25% threshold.

This 5 percent threshold would be consistent with HHS Office of Civil Rights (OCR) Title VI LEP Guidance for written materials.

In addition, we strongly urge CMS to require oral interpretation in all languages at all times. Federal law requires oral interpretation be provided in the health and health insurance contexts for all languages.[4] The interim final rule proposes to establish new precedent in requiring oral interpretation only in the languages meeting the 10% threshold and is inconsistent with OCR' LEP Guidance.

See also Mara Youdelman and Jan Perkins, National Health Law Program, "Providing Language Services in Small Health Care Provider Settings: Examples From the Field," April 2005. Available at http://www.commonwealthfund.org/usr_doc/810_Youdelman_providing_language_services.pdf.

[3] Asian Pacific American Legal Center and Asian & Pacific Islander American Health Forum, "California Speaks: Language Diversity and English Proficiency by Legislative District," available at http://www.apiahf.org/index.php/component/content/article/332.html.

[4] Title VI of the Civil Rights Act of 1964, amended as 42 USC § 2000d.

We appreciate the opportunity to comment on the proposed Rule and welcome future opportunities to work together.

Respectfully,

Kathy Lim Ko
President & CEO
Asian & Pacific Islander American Health Forum