NSCLC
National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

September 30, 2013

Via www.regulations.gov

U.S. Department of Health and Human Services
Office for Civil Rights
Attn: 1557 RFI (RIN 0945-AA02)
Hubert Humphrey Building, Room 509F
200 Independence Avenue SW
Washington DC 20201

Re: 1557 RFI (RIN 0945-AA02)

The National Senior Citizens Law Center is pleased to submit these comments in response to the 1557 Request for Information (RFI) issued by the Office of Civil Rights at the Department of Health and Human Services (HHS).

The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults, especially women, people of color and other disadvantaged minorities. Ensuring access to Medicare and Medicaid programs and improvement in their quality have been priority issues for our organization for decades.

NSCLC has joined in detailed comments submitted by the Disability Rights Education and Defense Fund (DREDF) and by the National Language Access Advocates Network (N-LAAN). We also submit these separate briefer comments addressing a few of the issues that are most important to the populations we serve.

Understanding the Current Landscape

1. Experiences of Discrimination

Sexual orientation. NSCLC and partner organizations collected experiences of older adults facing discrimination in nursing homes and assisted living facilities because of their sexual orientation or gender identification. The report, *LGBT Older Adults in Long-Term Care Facilities: Stories from the Field,* includes numerous examples of situations in which LGBT seniors were denied needed services in long term care facilities. We urge HHS to review the report and the problems it highlights. www.nsclc.org/index.php/lgbt-older-adults-in-long-term-care-facilities-stories-from-the-field/

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Language and Disability. The comments submitted by N-LAAN and others serving limited-English proficient individuals have highlighted the severe access problems that LEP individuals have faced in access to health care. Similarly, DREDF's comments set out problems faced by persons with disabilities.

2. Program coverage

Low income older adults increasingly are receiving their health –both Medicare and Medicaid--through managed care organizations. Today, approximately 28% of Medicare beneficiaries are enrolled in Medicare Advantage plans.[1] Well over three-quarters of the Medicaid population is enrolled in managed care.[2] The increasing reliance on managed care plans to organize and deliver federally funded or subsidized health care offers both opportunities and challenges for language access.

Managed care plans, federally administered by Medicare and Medicaid, are programs providing health care. As such, they are subject to the non-discrimination regulations, promulgated under Title VI. All interactions managed care plans have with members, whether or not those activities involve health care providers directly, affect the ability of plan members to access their health care.

To access care, plan members need quality language assistance at call centers, during plan appeals, on nurse help lines, in medication therapy management programs and at every point where they interact with the plan. The obligation to provide appropriate language services extends to out-of-plan specialists, laboratories, or providers who receive patient referrals from the plan.

Further, because in the managed care context, policy and process documents are as important to accessing care as documents directly about that care, "vital documents" must be defined to include not just the Evidence of Coverage, Explanations of Benefits, provider lists and other standard member materials, but also particularized notices about coverage and care plans, service denial and reduction notices, appeals correspondence and other notices that affect rights to or access to services. Section 1557 regulations should address these requirements.

Compliance and Enforcement Approaches

We urge HHS to employ the entire arsenal of enforcement approaches to ensure genuine progress in enforcement of the rights protected by Section 1557.

[1]Kaiser Family Foundation, Medicare Advantage 2012 Spotlight: Enrollment Market Update (June 2013), http://kff.org/medicare/issue-brief/medicare-advantage-2013-spotlight-enrollment-market-update/.
[2] See Medicaid Managed Care Enrollment Report at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.

Focus on Medicare Part B providers. For LEP older adults, one of the most important aspects of Section 1557 is the fact that the provision abolishes the exclusion of Medicare Part B providers from Title VI coverage. This change offers a huge opportunity to address health disparities among LEP older adults. But it also offers a significant challenge in educating the thousands of doctors and other Part B providers who are unfamiliar with Title VI and its obligations.

The learning curve for these providers is significant. CMS pays these providers and is well positioned to bring the message to Part B providers about their responsibilities.

An effective approach to getting compliance from this group must include a major education effort with physicians. If language access rights are to become real, provider buy-in, particularly for physicians, is critical. Providers need to be educated not only about their obligations but also about why compliance is important to the health care of their patients. They also need practical guidance in how to fulfill their obligations. While HHS/CMS clearly cannot and should not do this alone, it is important that the agency devote resources to working with provider groups, managed care organizations and others. Use of the Medicare Learning Network, www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/mlngeninfo, is another avenue for provider education. Education combined with enforcement will be significantly more effective than enforcement alone.

Monitoring. CMS' monitoring plan must place the burden on the agency, and not the LEP individual alone, to identify and rapidly resolve violations. An effective language access enforcement program must include proactive approaches by HHS, such as secret shopper surveys, to test whether appropriate language assistance is available. HHS cannot rely exclusively on individual complaints. LEP individuals, particularly those who also are frail and poor, are reluctant to complain and many do not even know that they have the right to language assistance. They should not bear the burden of identifying violations. CMS already uses secret shopper calls to assess plan compliance with Medicare marketing rules during the Annual Election Period and also uses the secret shopper mechanism to determine managed care plan compliance with call center interpreter standards. [3] This kind of monitoring needs to be expanded so that compliance by plans and providers can be adequately assessed.

Managed Care. As noted above, Medicare beneficiaries, particularly those who are dually eligible for Medicare and Medicaid, increasingly receive their care through managed care plans. This fact raises several concerns related to enforcement.

Addressing civil rights complaints: We share the concerns expressed in the DREDF comments that civil rights violations are, and may continue to be, treated as simple

[3] See, e.g., CY2012 Annual Election Period Marketing Surveillance Summary Report (Sept. 2012), available at www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/Market-Surveillance-Summary-AEP-Report-CY-2012.pdf

grievances by Medicare and Medicaid managed care plans and put in the same category as rudeness or poor customer service. HHS must ensure that regulations and guidance identify these issues separately and ensure that complaints are addressed in light of Title VI and *Olmstead* and that there is HHS oversight to identify situations where investigation and enforcement are appropriate.

Using contracts to ensure compliance: For Medicare and Medicaid managed care, besides the statutory enforcement mechanisms, CMS and HHS also have the ability to impose contractual obligations on plans, to require reporting on Section 1557 compliance, and to use quality withholds and other financial incentives to improve performance. We ask that the agency work aggressively to include specific translation, interpretation and cultural competency requirements in contracts with managed care providers. While these measures are a supplement and not a substitute for broader enforcement efforts, they are levers that CMS and HHS should use, particularly because they allow a more granular approach than is usually available through regulations alone. We note that CMS already does this in a limited way by requiring in the Medicare Managed Care Manual that Medicare plans to provide interpreter services at call centers. In addition, timely access to interpreters is one of the measures against which Medicare Advantage and Medicare Part D plans are measured when awarding star ratings. The ratings are a factor in plan renewal and low ratings can also lead to enrollment sanctions.[4] Much more needs to be done, particularly with respect to measuring and incentivizing language access in provider offices but the current contractual requirements are a foundation on which more robust language access requirements can be built.

Translation thresholds: For language access, another critical element—particularly for managed care--is thresholds for translation requirements. Translation services should be subject to thresholds that operate as mandatory minimum requirements rather than optional "safe harbors."[5] We strongly recommend HHS adopt new policy setting forth that the failure to translate documents when languages meet the percentage or numeric threshold, as outlined below, is evidence of non-compliance with Title VI.

We recommend that written translations (websites, vital documents, outreach and education materials) be translated for each language that makes up 5% or 500 persons, whichever is less, of the population of persons eligible to be served or likely to be affected by the program or recipient in the service area. This recommendation combines existing guidance and regulations from Federal agencies. In 2003, HHS' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin

[4] See 2014 Call Letter at pp. 79, and 81, available at www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2013.pdf.
[5] Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47,319 (Aug. 8, 2003) [hereinafter HHS LEP Guidance].

Discrimination Affecting Limited English Proficient Persons ("HHS LEP Guidance"), defined the expectations for translation of vital documents as 5% or 1,000 LEP individuals in a federal fund recipient's service area.[6] A Department of Labor (DOL) regulation prior to passage of the ACA required group health plans to translate summary plan descriptions into a non-English language when 500 or 10% LEP participants in that plan speak that language.[7]

It is critically important to have a combination of percentage and numerical thresholds and not rely on percentages alone. As has been seen with Medicare marketing regulations[8] that set a 5% threshold for translation of certain marketing documents, reliance on a percentage alone leaves millions of LEP individuals without access to needed translations, particularly when service areas are statewide. In 2012, for example, the 5% of service area standard for Medicare Prescription Drug Plans (PDPs) resulted only in Spanish translations requirements and those requirements did not apply to all states. There was not a single state where PDPs were required to translate materials into Chinese, the next most prevalent language, or into any non-English language other than Spanish.[9]

Thus we urge OCR to combine the existing standards and adopt the lower 5% or 500 in a service area threshold for translation of vital documents, websites, outreach and education materials. All entities receiving federal funding should be subject to this standard, including but not limited to States, managed care plans and providers offering Medicare and Medicaid services, Health Exchanges, Qualified Health Plans (QHP), and Navigators and In-Person Assisters. These entities must translate vital documents and websites into a non-English language when 5% of the population or 500 individuals (whichever is smaller) in their service area speak that language.

Service areas relevant for the application of thresholds should be program-specific, encompassing the geographic area where persons *eligible to be served or likely to be directly or significantly affected* by the recipient's program are located.

We also recommend that HHS require the inclusion of taglines in **15 languages** on all notices and websites informing LEP individuals of their right to language services and how to access them.

[6] *Id.*
[7] 29 C.F.R. 2520-102-2(c).
[8] 42 C.F.R. 423.2264(e).
[9] See Memoradum from Cynthia G. Tudor and Danielle R. Moon (July 15, 2011), available at www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Update2012TranslatedMaterialsRequirementsandResourcesFinalHPMSMemo_071511.pdf

Unlike translations of written documents, oral interpretation services should not be subject to any thresholds for when they should be offered but be available "on demand" and free of charge.

Conclusion

Regulations implementing Section 1557 offer an important opportunity to advance the civil rights and improve the health of individuals who have been denied full participation in and access to the health care system. We urge HHS to move forward with timely and robust regulations.

Thank you for the opportunity to submit these comments.

Sincerely,

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