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HAND-DELIVERED

Health Care Financing Administration
Room 413 -G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Attention: HCFA-2001-P

Re: Comments regarding Cultural and Linguistic Competency Requirements in the
Balanced Budget Act - Medicaid Managed Care Proposed Regulations

To Whom It May Concern:

The National Health Law Program (NHeLP) submits these comments on behalf of itself and the organizations listed below in response to the Notice of Proposed Rulemaking, published on September 29, 1998, concerning implementation of the Balanced Budget Act's Medicaid Managed Care provisions. These comments address only those provisions relating to the responsibility of the state and the Managed Care Entity (MCE) to provide culturally and linguistically competent services to beneficiaries.

The National Health Law Program is a non-profit, civil rights organization that advocates for justice in health care for low-income people. For almost 30 years we have provided technical expertise to thousands of attorneys and providers serving low-income Medicaid beneficiaries. These comments not only reflect our technical legal expertise in Medicaid and managed care, but our considerable knowledge of the legal obligations of federally funded health providers to comply with Title VI of the Civil Rights Act and other laws that prohibit discrimination based on national origin.

Summary and Background

Title VI of the Civil Rights Act states: "No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be

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subjected to discrimination under any program or activity receiving Federal financial assistance.”¹ Because federal funding of health care is pervasive, nearly every health care provider is bound by Title VI. The U.S. Department of Health and Human Services (HHS) has long recognized that Title VI requires linguistic accessibility to health care. In addition, the Office for Civil Rights (OCR) within HHS has consistently interpreted Title VI to require the provision of qualified interpreter services and translated materials at no cost to patients.

Existing Medicaid regulations explicitly require state programs to operate in a manner consistent with Title VI.² The Health Care Financing Administration requires states to communicate with beneficiaries both orally and in writing in a language understood by the beneficiary and to provide interpreters at Medicaid hearings.³ Medicaid regulations also provide heightened protections for people who reside in long-term care facilities and to children and youth through Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT).⁴

Although the preamble to the September 29, 1998 proposed rules asks states to pay close attention to ethnic and racial minorities throughout the health care delivery process, the regulations contain only three provisions that make explicit reference to cultural and linguistic competency requirements. While the proposed rules do call for each participating provider to ensure that services are provided in a culturally competent manner, overall, the rules lack the detail needed to ensure that States and MCE’s understand their obligations to ensure culturally and linguistically appropriate services for Medicaid beneficiaries at all levels of the health care delivery system.

Despite the clear requirements under Title VI to ensure that health programs are linguistically and culturally accessible, our experience and research demonstrate that in communities throughout the country, providers continue to muddle through their contacts with limited-English speakers, relying upon their own rudimentary skills, patients’ family members, hospital service employees and other untrained interpreters. Too often, these practices reflect providers’ lack of familiarity with their legal obligations under federal and state laws.⁵

The failure to provide culturally and linguistically appropriate health services contributes to poor health outcomes for racial and ethnic minorities. Over 50 percent of Medicaid

¹ 42 U.S.C. § 2000d. *See also* 45 C.F.R. § 80, app. A (1994) (listing examples of federal financial assistance, including Medicare, Medicaid, Maternal and Child Health grants).

² 42 C.F.R. § 435.901 (1994).

³ HCFA, *State Medicaid Manual* §§ 2900.4 and 2902.9 (Mar. 1990).

⁴ *Id.*, § 5121.A (Apr. 1990); 42 C.F.R. § 483.10 (b)(1) (1994).

⁵ *See* NATIONAL HEALTH LAW PROGRAM, *Ensuring Linguistic Access in Health-care Settings: Legal Rights and Responsibilities* (Jan. 1998) (available from The Henry J. Kaiser Family Foundation, 800-656-4533, Pub. No. 1362).

beneficiaries are members of racial or ethnic minority groups. Moreover, the numbers of limited English speaking Medicaid beneficiaries are growing dramatically, and these trends will continue. In short, now is the time for HCFA to provide clear guidance to states and MCEs to ensure that beneficiaries are served in a culturally competent manner in compliance with the law. The need for clear rules is even greater in managed care because managed care's goal of reducing costs may prevent or minimize investment in services that will improve the cultural competency of the organization.⁶

Section by Section Analysis

Information requirements — proposed 42 C.F.R. § 438.10(b), 63 Fed. Reg. at 52078

Comment: This rule requires state agencies to establish a methodology for determining the “prevalent languages” spoken by populations in a geographic area and to make information available in those languages.⁷ However, the regulation does not identify the methodology for determining prevalent languages. We suggest that the methodology for determining prevalent languages be included in the regulation. Specifically, we recommend that HCFA:

- ◆ promulgate beneficiary protections modeled after the standard used by the California Department of Health Services. This standard calls for a numeric threshold of 3,000 recipients who are limited English proficient in an MCE's service area, or 1,000 recipients in a postal Zip code, or 1,500 such recipients in any two contiguous Zip codes. MCEs would be required to provide translated written materials for any groups that meet the threshold, and to have oral interpretation/bilingual services available for each enrollee or potential enrollee, regardless of numeric threshold. At the very least, we suggest a regulation providing that, at minimum, states will assure that MCEs make written information available in languages spoken by 5 percent or more of the population *in the MCE's service area*.
- ◆ coordinate these regulations with the HHS Office for Civil Rights by explicitly integrating minimum guidelines set forth in OCR's January 1998 memorandum.⁸

⁶ See NEW YORK TASK FORCE ON IMMIGRANT HEALTH AT THE NEW YORK UNIVERSITY SCHOOL OF MEDICINE, DIVISION OF PRIMARY CARE, *Report on Research Project-Access through Medical Interpreter and Language Services*. Summary available on the Internet at: <http://www.hhs.gov/progorg/ocr/atmil.htm>.

⁷ For the preamble discussion to this regulation, see 63 *Fed. Reg.* at 52029. For the proposed regulation itself, see 63 *Fed. Reg.* at 52078.

⁸ U.S. Department of Health and Human Services Office for Civil Rights, *Guidance Memorandum Title VI Prohibitions Against National Origin Discrimination — Persons with Limited-English Proficiency* (Jan. 1998).

The regulation should be amended to require MCEs to:

- ▶ have procedures for identifying language needs of patients;
 - ▶ develop written procedures regarding interpreter services;
 - ▶ disseminate procedures to staff and network providers;
 - ▶ provide staff training on cultural competence;
 - ▶ prohibit the use of minors to interpret;
 - ▶ prohibit the use of family and friends to interpret without first making the beneficiary an offer of *no cost* interpretation services;
 - ▶ make bilingual care givers available to the greatest extent possible and assure the availability of qualified interpreters.
- ◆ clearly place MCEs on notice of their obligations to comply with the civil rights laws by incorporating reference to the Title VI statute and regulations, 45 C.F.R. § 80 et seq.
 - ◆ adopt requirements similar to nursing home protections, including, for example, requirements that MCEs fully inform members in a language that they can understand of their total health status, including their medical condition.⁹

Rationale: The proposed regulation attempts to satisfy dual goals of allowing maximum flexibility for states and providing better beneficiary protections. While such a balance may be possible to achieve, this rule weighs too heavily in favor of state flexibility at the expense of beneficiary protections for an extremely vulnerable population. By simply requiring that some methodology be used to determine prevalent languages, the regulation conceivably allows a state agency to abide by this regulation yet still exclude large populations of beneficiaries with limited English proficiency. The fact that a state employs a methodology does not imply that the methodology is reasonable or sound or that the state is in compliance with the requirements of Title VI of the Civil Rights Act. In short, deciding which populations of beneficiaries are to receive translated materials is a problem that calls for a minimum regulatory standard. States can then be afforded flexibility to vary the standard as long as it continues to meet the pertinent federal laws.

Access Standards. Availability of Services — proposed 42 C.F.R. § 438.306(e)(4), 63 Fed. Reg. at 52083

⁹ See 42 C.F.R. § 483.10(b).

Comment: The regulation should read as follows:

Access Standards

438.306 Availability of services.

...

(e) Provision of services. The State must ensure that each MCO complies with the requirements of this paragraph.

...

(4) Cultural considerations. The MCO ensures that services are provided in a culturally competent manner to all enrollees. Cultural competency includes, but is not limited to, the following:

(i) The language requirements of § 438.10;

(ii) Full attention is given to racial and ethnic minorities throughout the health care delivery process;

(iii) The MCO's network of providers includes an appropriate number of care givers who are knowledgeable about the values, beliefs, traditions, customs, and parenting styles of the community;

(iv) Network providers have knowledge of any enhanced medical risks associated with the racial, ethnic, and socioeconomic characteristics of the populations beings served.

Rationale: While the proposed regulation laudably includes the concept of cultural competency, the term is left undefined. The regulatory language, “including at least the language requirements of § 438.10,” leaves open a possible interpretation that simply providing interpreter and translation services is adequate to meet the requirement. Moreover, interpreter and translation services are only a part of what constitutes culturally competent health care delivery. On the other hand, the preamble (63 *Fed. Reg.* at 52045) provides indispensable guidance to MCOs on cultural competency. In general, cultural competency requires “awareness of the culture of the population being served.” Specifically, the preamble notes:

- ▶ State agencies should require managed care organizations to give full attention to racial and ethnic minorities throughout the health care delivery process.
- ▶ Interpreter and translation services and alternative formats must be provided when language barriers exist, including sign language for the hearing impaired, and large print text, audio tapes and braille for those with impaired vision.
- ▶ Managed care organization’s network of providers should include an appropriate number of care givers who are aware of the values, beliefs, traditions, customs, and parenting styles of the community.

- ▶ Network providers should have knowledge of any enhanced medical risks peculiar to the racial, ethnic, and socioeconomic factors of the populations beings served.

This information should be incorporated into the regulation so that HCFA’s intent will not be lost or ignored.¹⁰

Information about the grievance system — proposed 42 C.F.R. § 438.414(b)(4), 63 Fed. Reg. at 52088

Comment: The requirement that MCOs provide toll-free numbers and have adequate TTY and interpreter capability are important and should be preserved. In addition:

- ◆ HCFA should include a requirement that MCOs engage in some outreach to beneficiaries with limited English proficiency to inform them of the service. Such outreach, to the extent possible, should be conducted in the beneficiaries’ language.

Rationale: The mere existence of telephone interpreter capability does not ensure that beneficiaries with limited English proficiency will know of or use the phone system.

- ◆ We strongly urge these regulations be amended to require interpreters, at no cost to enrollees, during the grievance process.

Rationale: HCFA’s *State Medicaid Manual* requires states to provide interpreters at Medicaid fair hearings.¹¹ This due process protection is no less important during the MCO-level grievance process.

Additional Protections Are Needed:

All of the following suggested additional regulations are tied to existing requirements of federal civil rights and/or Medicaid law, and, as such, should be no surprise to states or Medicaid-participating MCEs:

- ◆ At § 438.700(a)(3), HCFA should add as a basis for sanctions: “Acts to discriminate among enrollees on the basis of their health status, race, color or national origin, or requirements for health care services. . .”

¹⁰ For the preamble discussion to this regulation, see 63 Fed. Reg. at 52045. For the proposed regulation itself, see 63 Fed. Reg. at 52083.

¹¹ HCFA, *State Medicaid Manual* § 2902.9.

Rationale: The regulations provide that states cannot enter into or renew a contract with an MCO until the state has established intermediate sanctions for violations.¹² The omission of Title VI requirements from the list of sanctionable activities reduces the likelihood that MCOs will comply with cultural competency requirements.

- ◆ Marketing regulations need to be amended to require that enrollment activities and enrollment brokers have capacity to communicate effectively with limited English speaking beneficiaries. The regulation also needs to require states to assure that marketing materials are being translated throughout the service area covered by the managed care program.¹³
- ◆ A regulation should require MCOs to record information by race/ethnicity of the enrollee.

Rationale: The civil rights regulations require HCFA to collect data sufficient to enforce Title VI of the Civil Rights Act.¹⁴ The agency will not be able to effectively enforce the civil rights laws if it does not collect this information.

- ◆ A regulation (or at least the preamble) should reflect HEDIS 3.0 standards for reporting on providers and staff who speak a language other than English.¹⁵
- ◆ Provider network regulations should include a provision on nondiscrimination against providers who serve limited English proficient populations.¹⁶
- ◆ Provider network regulations need specifically to incorporate for states and MCOs the statutory requirements for accessible providers in the Vaccines for Children program.¹⁷

¹² Proposed 42 C.F.R. § 438.700, 63 *Fed. Reg.* at 52089.

¹³ The marketing regulation is found at proposed 42 C.F.R. § 438.104.

¹⁴ 28 C.F.R. § 42.406(a).

¹⁵ 2 National Committee for Quality Assurance, HEDIS 3.0 Health Plan Employer Data & Information Set at 97-98 (Jan. 1997).

¹⁶ The provider network regulation is found at proposed 42 C.F.R. § 438.314.

¹⁷ See 42 U.S.C. § 1396s(c)(3)(B) (“identif[y], with respect to any population of vaccine-eligible children a substantial portion of whose parents have a limited ability to speak the English language, those program-registered providers who are able to communicate with the population involved in the language and cultural context that is most appropriate.”)

Thank you for the opportunity to comment on the proposed rules.

Sincerely,

Claudia Schlosberg and
Francis Cheng on behalf of the
National Health Law Program

These comments have been endorsed by:

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Alzheimer's Association of Eastern Massachusetts
American Association on Mental Retardation
American Federation of State, County and Municipal Employees, AFL-CIO
Asian American Legal Defense and Education Fund, New York, New York
Asian Law Alliance, San Jose, California
Asian Law Caucus, San Francisco, California
Asian Pacific American Legal Center, Los Angeles, California
Association of Asian and Pacific Community Health Organizations, Oakland,
California
Baltimore HealthCare Access, Inc.
Mary T. Banfich, Immaculate Conception Catholic Church-Hispanic Ministry,
Durham, North Carolina*
California Primary Care Association
California Protection and Advocacy, Inc.
California Women's Law Center
CASA of Maryland, Inc.
Center for Health Care Rights, Los Angeles, California
Center for Public Policy Priorities - Texas
Center on Disability and Health, Washington, D.C.
Center on Poverty Law and Economic Opportunity, Oakland
Chicago-Kent College of Law
Children and Adults with Attention Deficit Disorders, Landover, Maryland
Clinica del Pueblo, Washington, D.C.
Coalition for Humane Immigrant Rights of Los Angeles
Columbia Legal Services, Seattle, Washington
Community Health of South Dade, Inc.
Florida Immigrant Advocacy Center
Florida Impact
Florida Legal Services

Friends Committee on National Legislation (Quaker), Washington, D.C.
Gay Men's Health Crisis, New York, New York
Greater Boston Legal Services
Greater Upstate Law Project, Rochester, New York
Health Promotion Council of Southeastern Pennsylvania
Infants at Risk, Cheverly, Maryland
Indiana Task Force on Managed Care Issues
Institute for Community Outreach and Research, Tulsa, Oklahoma
Latino Commission on AIDS, New York, New York
Legal Aid Society, New York, New York
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Michigan Legal Services
Michigan Protection and Advocacy Service, Inc.
Migrant Legal Action Program, Washington, D.C.
National Asian Pacific American Legal Consortium, Washington, D.C.
National Association of Area Agencies on Aging
National Association of People with AIDS
National Association of Protection and Advocacy Systems, Inc.
National Association of School Psychologists
National Council of La Raza
National Employment Law Project
National Immigration Law Center
National Senior Citizens Law Center
New Jersey Protection and Advocacy, Inc.
New York Association for New Americans, Inc.
Northern California Lawyers for Civil Justice
North Carolina Justice and Community Development Center
Northern Virginia Family Service
Oregon Advocacy Center
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Polk, Highland, Hardee AIDS Services and Education, Winter Haven, Florida
Program Assisting Refugee Assimilations, Grand Rapids, Michigan
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Roanoke Refugee and Immigration Services, Roanoke, Virginia
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Virginia Poverty Law Center
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