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United States Government Accountability Office
Washington, DC 20548

July 30, 2009

The Honorable Nydia M. Velázquez
Chairwoman
Committee on Small Business
House of Representatives

Subject: *Centers for Medicare & Medicaid Services: CMS Should Develop an Agencywide Policy for Translating Medicare Documents into Languages Other Than English*

Dear Chairwoman Velázquez:

The Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for administering the Medicare program for nearly 45 million beneficiaries, including beneficiaries with limited English proficiency (LEP)—meaning they may not be proficient or are limited in their ability to communicate in the English language. Medicare beneficiaries face a complex set of health care choices that require them to obtain information about the comparative benefits, costs, and quality of available options. CMS is responsible for providing clear, accurate, and timely information about this program and making the information accessible to beneficiaries.

Under section 601 of Title VI of the Civil Rights Act of 1964, entities that receive federal financial assistance are prohibited from discriminating against or otherwise excluding individuals from their programs or activities on the basis of race, color, or national origin.[1] In 1964, as directed under section 602 of Title VI, HHS first published regulations applying these prohibitions to entities receiving federal financial assistance from HHS, including health care organizations.[2] In 2000, Executive Order 13166 was published, requiring federal agencies to take certain steps to clarify Title VI requirements.[3] Specifically, this order required federal agencies to publish guidance addressing how their recipients of federal financial assistance can

[1]Pub. L. No. 88-352, Tit. VI, § 601, 78 Stat. 241, 252 (1964) (codified, as amended, at 42 U.S.C. § 2000d). In this report, we refer to Title VI of the Civil Rights Act of 1964, as amended, as Title VI.

[2]The Department of Health, Education, and Welfare, the predecessor of HHS, published these regulations. See *Non-Discrimination in Federally-Assisted Programs of the Department of Health, Education, and Welfare—Effectuation of Title VI of the Civil Rights Act of 1964*. 29 Fed. Reg. 16,298-16,305 (Dec. 4, 1964) (codified, as amended, at 45 C.F.R. Part 80).

[3]Executive Order 13166, *Improving Access to Services for Persons with Limited English Proficiency*, 65 Fed. Reg. 50,121-22 (Aug. 16, 2000).

provide LEP individuals meaningful access to programs and activities that recipients normally provide in English, and thus do not discriminate on the basis of national origin in violation of Title VI and implementing regulations. As a result, HHS published guidance, which clarified these responsibilities for all recipients of federal financial assistance from HHS.[4] This guidance provides a method of analysis for providers to use in determining the extent to which oral and written language assistance services for LEP individuals is needed, if any, in order to comply with Title VI and the implementing regulations.[5]

Executive Order 13166 also required federal departments and agencies, including HHS, to examine the services they provide and prepare a plan identifying the steps they will take to provide LEP individuals with meaningful access to the agencies' programs and activities. Accordingly, HHS developed an LEP strategic plan that identified the steps the department and its agencies, including CMS, intended to take to help ensure timely access to language assistance services by eligible LEP beneficiaries to their programs and activities.[6] For example, the plan includes elements related to providing oral language assistance and written translations of vital program documents in languages other than English where there are significant numbers of LEP beneficiaries. The plan also indicates that HHS agencies will strive to implement written policies and procedures related to plan elements, including written translations of program documents.

As immigration patterns have changed and more languages are spoken in the United States, some providers have reported that the cost burden for providing language services to LEP beneficiaries—such as translating documents into additional languages and providing interpreters—has increased as well. While recognizing that health care providers receiving federal financial assistance have certain responsibilities under Title VI and implementing regulations, some organizations representing them and organizations interested in LEP issues have requested CMS to do more to ease the burden providers face in communicating with beneficiaries with LEP, such as translating Medicare documents into additional languages.

You asked us to review CMS's language access policies, efforts to translate Medicare documents, and the challenges health care providers face in communicating with LEP beneficiaries. In this correspondence, we (1) examine the extent to which CMS translates Medicare documents into languages other than English and (2) describe the challenges health care providers may face in communicating with LEP beneficiaries, including translating Medicare and other documents.

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[4]HHS, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, 68 Fed. Reg. 47,311 (Aug. 8, 2003).

[5]Recipients of federal financial assistance from HHS do not include certain providers, such as physicians, who only receive Medicare Part B payments. However, if these providers receive federal financial assistance from HHS in other forms such, as through Medicaid, then they are covered by Title VI and implementing regulations.

[6]HHS, *Strategic Plan for Improving Access to HHS Programs and Activities by Limited English Proficient (LEP) Persons* (Washington, D.C.: Dec. 15, 2000).

Scope and Methodology

To determine the extent that CMS translates Medicare documents into languages other than English, we first reviewed Executive Order 13166 and the LEP Strategic Plan developed by HHS, and interviewed staff from the HHS Office for Civil Rights. To identify CMS's specific language access policies, we interviewed officials from various components within CMS, including the Office of External Affairs—in particular the Creative Services Group and the Partner Relations Group—and the Center for Drug and Health Plan Choice. To identify Medicare documents that are directed to beneficiaries and include key program information, we interviewed officials from CMS and provider organizations; reviewed available lists of Medicare documents compiled by CMS, the American Hospital Association (AHA), and the National Health Law Program (NHeLP); and reviewed documents available on CMS's Web sites, including www.cms.hhs.gov and www.medicare.gov, between January 2009 and April 2009. Using these sources, we identified 134 Medicare documents. The 134 documents we identified only include documents such as forms, notices, and publications that CMS created and may be used by beneficiaries. We specifically did not include documents that CMS considers model notices, which are produced by CMS and contain CMS-approved language that may be modified and used by providers or other entities. To determine the extent to which these documents were translated into languages other than English, we first identified the CMS components responsible for each of the 134 documents. We then interviewed each component to determine which documents it translated into other languages and the rationale for the translation decisions. To confirm that documents identified were translated and to assess the availability of those documents, we conducted an Internet search of CMS's Web sites between September 2008 and June 2009.

To identify current language access policies or practices employed by health care providers and the challenges these providers encountered in communicating with LEP individuals, including translating Medicare and other documents, we reviewed reports, surveys, and letters, and interviewed officials of health care provider organizations—AHA, the American Medical Association (AMA), the National Association of Community Health Centers (NACHC), and the National Association of Public Hospitals and Health Systems. Further, we interviewed officials at the Joint Commission about their ongoing revision to the hospital accreditation standards to include standards for culturally competent patient-centered care. Similarly, we reviewed reports and surveys and interviewed officials of organizations interested in LEP issues, including NHeLP and the National Senior Citizens Law Center (NSCLC). We also interviewed representatives from the Asian American Pacific Island Health Forum (AAPIHF), the AARP Public Policy Institute, the National Federation of Independent Businesses, and the National Academy of Social Insurance. In addition, we convened a focus group, which was facilitated by an organization called "Out of Many, One" to discuss challenges providers face in communicating with LEP beneficiaries. The focus group was comprised of representatives of several additional organizations, including New York Lawyers for the Public Interest, National Partnership for Women and Families, Summit Health Institute for Research and Education, La Fe Policy Research and Education Center, Office of the Governor of Puerto Rico, Southeast Asia Resource Action Center, California Pan-Ethnic Health Network, National Council of La Raza, National Association of State Offices of Minority Health, and Brookings. To provide examples of the challenges health care

providers experience, we also interviewed four officials representing different types of health care providers. We interviewed the chief executive officers of an oncology practice and a community health center and spoke with officials representing two health care systems. To further understand the complexities involved with translating Medicare documents into languages other than English, we consulted with a number of translators who were certified by the American Translators Association (ATA) and had experience in translating medical documents. Further, we interviewed organizations representing providers and groups interested in LEP issues to understand the extent to which these groups were involved in the development of CMS's language access policies.

We undertook this performance audit from September 2008 to July 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results in Brief

In summary, CMS components translated 87 percent of the 134 Medicare documents we identified into Spanish and, to a limited extent, other languages, including Chinese, Korean, and Vietnamese. The translated documents provide information about the Medicare program, specific health care conditions, and information specific to an individual beneficiary's Medicare coverage. For example, CMS translated into Spanish *Medicare & You*, a handbook that is sent to all Medicare beneficiaries every year, which summarizes program benefits and beneficiaries' rights and protections, and answers the most frequently asked questions about the program. CMS officials we interviewed were unaware of any agencywide translation policy related to Medicare documents, echoing findings from a prior GAO report that identified shortcomings in CMS's implementation of HHS's LEP plan.[7] Because of the absence of an agencywide translation policy, the extent to which Medicare documents were translated depended entirely on decisions made by individual CMS components. For example, the Office of External Affairs and the Center for Drug and Health Plan Choice—the two CMS components that translated the majority of the documents into Spanish—did so because it is the most common language spoken by LEP Medicare beneficiaries. The roughly 13 percent of documents that were not translated by CMS varied in terms of their content. Some were templated forms or notices that require health care providers to add beneficiary-specific information, including information related to benefit exclusions or changes to the beneficiary's portion of costs. In addition, some documents that were not translated contain information about how to manage certain health conditions or the Medicare program—information similar to what is included in other documents that CMS translated into Spanish. In response to our recommendation in the 1-800-MEDICARE report, CMS recently appointed an individual in its Office of Equal Opportunity and Civil Rights (OEOCR) to develop an LEP plan, but this plan is still in development, and agency officials have not informed us how their LEP plan will address the translation of written materials. Without an

[7]See GAO, *Medicare: Callers Can Access 1-800-MEDICARE Services, but Responsibility within CMS for Limited English Proficiency Plan Unclear*, GAO-09-104 (Washington, D.C.: Dec. 29, 2008).

agencywide policy, there is no guarantee that CMS can ensure that Medicare documents containing vital beneficiary information will consistently be translated in the future for the various groups of beneficiaries that have limited English proficiency.

Under Title VI and implementing regulations, health care providers that receive federal financial assistance must take reasonable steps to ensure that eligible LEP individuals have meaningful access to their services. While our review focused primarily on the challenges of translating Medicare documents, provider organizations, other groups interested in LEP issues, and health care providers we interviewed told us that they face additional challenges in communicating with LEP beneficiaries—such as the high cost of providing translation and interpretation services and difficulty identifying qualified translators and interpreters. Health care providers and organizations representing them told us that translating Medicare documents into languages other than English and Spanish is challenging. These providers also indicated that most of the documents they translate are documents they have developed for their patients, such as consent forms or discharge information, rather than Medicare documents CMS has created. In lieu of translating Medicare documents, three providers we spoke to told us that they sometimes use bilingual staff or hire interpreters to perform "sight" translations—reading the Medicare document to the beneficiary in their primary language—or use a variation, where the provider reads the document and an interpreter orally interprets what has been said. Although CMS has translated the majority of Medicare documents into Spanish, organizations representing health care providers and the LEP population told us it would be helpful if CMS were to translate Medicare documents into additional languages. This would prevent multiple providers from translating the same documents and reduce the need for "sight" translations. However, this would not alleviate the need to have interpreters or bilingual staff available during visits with LEP patients. Some health care provider organizations and other organizations told us they approached CMS about translating Medicare documents into other languages but typically received little or no response from the agency. However, CMS officials told us that they have developed partnerships with several external stakeholder groups to obtain their input. CMS also recently appointed an individual whose responsibility is to develop an LEP plan specific to CMS, and this official has begun meeting with external LEP organizations to address their concerns with the plan.

To improve the consistency and transparency of CMS's translation decisions, we recommend that CMS develop a written, agencywide policy that includes criteria for the translation of written documents as part of its LEP plan. In commenting on a draft of this correspondence, CMS generally agreed with our recommendation and said that it has developed a draft LEP plan that will include an agencywide strategic policy with criteria to ensure CMS-produced Medicare documents with vital beneficiary information are consistently translated. CMS and HHS also provided technical comments, which we incorporated as appropriate.

Background

CMS administers Medicare, a federal health insurance program that provides a variety of health care services to individuals who are 65 or older, have end-stage renal disease, or are disabled. Medicare includes four separate "parts" under which different types of services are covered. Individuals eligible for Medicare are entitled to hospital insurance, known as Part A, which helps pay for services such as inpatient hospital care and skilled nursing facility services following a hospital stay. Medicare beneficiaries may opt to enroll in supplemental medical insurance, known as Part B, which helps pay for services, such as physician and outpatient hospital services. Traditionally, Medicare has reimbursed providers for Part A and B services on a fee-for-service basis. In contrast, Medicare beneficiaries may choose to obtain this coverage from the Medicare Advantage program, known as Part C, where private health insurance plan sponsors offer Medicare Advantage plans (MA-plans) that cover Part A and B services for enrollees. Medicare beneficiaries may also choose to obtain coverage for outpatient prescription drugs through the prescription drug benefit, known as Part D. Under Part D, plan sponsors may offer MA-plans with prescription drug coverage, referred to as MA-PD plans, or stand-alone prescription drug plans.

Medicare providers generally are required to take reasonable steps to ensure meaningful access to their services for LEP beneficiaries. Section 601 of Title VI provides that no person shall "on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."[8] Section 602 of Title VI directs federal agencies to implement section 601 by issuing rules, regulations, or orders.[9] Accordingly, in 1964, HHS first published implementing regulations for entities receiving federal financial assistance from HHS, including health care organizations.[10]

On August 11, 2000, Executive Order 13166 was published, requiring federal agencies to take certain steps to clarify Title VI requirements.[11] Specifically, this order required federal agencies to publish Title VI guidance for their recipients of federal financial assistance that is consistent with guidance provided by the Department of Justice (DOJ). The order further provided that to assist other federal agencies, DOJ published general guidance which set forth compliance standards that federal financial assistance recipients must follow to ensure programs and activities normally provided by recipients in English are accessible to LEP persons, and thus do not discriminate on the basis of national origin in violation of Title VI and

[8]Pub. L. No. 88-352, § 601, 78 Stat. 241, 252 (1964) (codified, as amended, at 42 U.S.C. § 2000d).

[9]Pub. L. No. 88-352, § 602, 78 Stat. 241, 252 (1964) (codified, as amended, at 42 U.S.C. § 2000d-1).

[10]29 Fed, Reg. 16,298-16,505 (Dec. 4, 1964) (codified, as amended, at 45 C.F.R. Part 80).

[11]Executive Order 13166, *Improving Access to Services for Persons with Limited English Proficiency*, 65 Fed. Reg. 50,121-22 (Aug. 16, 2000).

implementing regulations.[12] In 2002, DOJ also published guidance addressing the Title VI obligations of its recipients to take reasonable steps to ensure access to programs and activities by LEP persons.[13] In DOJ's guidance, DOJ clarified that Title VI and implementing regulations required recipients of federal financial assistance from DOJ to take reasonable steps to provide meaningful access to LEP individuals based on an assessment that balances the following factors: (1) number or proportion of LEP individuals, (2) frequency of contact with the program and LEP individuals, (3) nature and importance of the program, and (4) resources available to the recipients and the costs of language assistance services.

Consistent with Executive Order 13166 and the DOJ guidance, HHS initially published guidance for federal financial assistance recipients, including Medicare providers, on August 30, 2000,[14] and later revised this guidance in August 2003.[15] HHS's guidance describes four factors that providers should consider in determining what language assistance services, if any, are necessary: (1) the number or proportion of LEP individuals served or encountered; (2) the frequency of these encounters (less frequent encounters with a language group may require a different approach than what would be required for daily encounters); (3) the importance of the program or service being offered and whether the denial or delay of service or information could have serious or even life-threatening implications for the LEP individual;[16] and (4) the resources available to the recipient, and costs.[17] According to HHS's guidance, these

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[12]*Enforcement of Title VI of the Civil Rights Act of 1964 – National Origin Discrimination Against Persons with Limited English Proficiency; Policy Guidance*, 65 Fed. Reg. 50,123 (Aug. 16, 2000).

[13]*Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, 67 Fed. Reg. 41,455 (June 18, 2002).

[14]*Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency*, 65 Fed. Reg. 52,762 (Aug. 30, 2000).

[15]*Guidance to Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, 68 Fed. Reg. 47,311 (Aug. 8, 2003). HHS modified this guidance, in part, in response to the Title VI guidance for recipients of federal financial assistance published by DOJ in 2002. This guidance clarifies that entities receiving federal financial assistance from HHS do not include certain providers, such as physicians, who only receive Medicare Part B payments. However, if these providers receive federal financial assistance from HHS in other forms, such as through Medicaid, then they are covered by Title VI and implementing regulations. In this report, we focus our discussion of the guidance on its application to Medicare providers.

[16]According to HHS's guidance, an example of an urgent and important service relates to communication of information concerning emergency surgery and obtaining informed consent prior to such surgery, thus requiring the need for immediate language assistance. Alternatively, if the activity is important, but not urgent—such as the communication of information about, and obtaining informed consent for, elective surgery, where delay will not have any adverse impact on the patient's health—language services are needed but may be delayed for a reasonable time without life-threatening implications.

[17]HHS's guidance states that smaller recipients with more limited budgets are not expected to provide the same level of language services as larger recipients with larger budgets. The guidance states that reasonable steps may cease to be "reasonable" when the costs imposed substantially exceed the benefits.

factors are designed to provide flexibility to health care providers, such as allowing providers to make an individualized assessment using these four factors to determine what language services the provider plans to offer. The guidance provides options for oral interpretation services for LEP individuals, such as hiring staff interpreters, contracting interpreters, or using telephone interpreter lines. The guidance also identifies criteria for written translations, such as how to determine what documents under its purview are considered "vital" and to translate these documents into the languages most frequently encountered.[18, 19]

Executive Order 13166 also required federal departments and agencies, including HHS, to examine the services they provide and prepare a plan identifying the steps they will take to provide LEP individuals with meaningful access to the agencies' programs and activities.[20] As required by the order, HHS developed a plan that identified the steps the department and its agencies would take to provide eligible LEP persons with meaningful access to the department's programs and activities, which would include CMS's administration of the Medicare program. The HHS LEP Strategic Plan, issued in December 2000, identified seven elements designed to meet HHS's goal of providing "access to timely, quality language assistance services to LEP persons." According to the plan, HHS addresses what its programs will do in terms of providing language assistance to beneficiaries with whom it directly interacts. HHS also explains that it will strive to implement each element of the plan, establishing priorities that best meet the needs of LEP individuals in the context of resource constraints. Table 1 shows that the plan includes elements related to assessing the language assistance needs and capacity at each HHS component; provisions for oral language assistance services and written translation of vital documents; written policies and procedures related to each plan element, as well as staff responsible for implementing them; and training of front-line managerial staff at the component and program levels.[21]

[18]HHS's guidance states that vital written materials could include consent and complaint forms; intake forms with the potential for important consequences; and written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services.

[19]The HHS guidance describes safe harbors to help recipients determine whether certain documents should be translated. The guidance states that if the recipient provides written translations of vital documents for each eligible language group that constitutes 5 percent or 1000, whichever is less of the population eligible to be served, except where the 5 percent is less than 50 persons, then such action will be considered strong evidence of compliance with the recipient's written translation obligations. These safe harbors are to be used as a starting point for recipients to consider when making decisions about whether to provide written translations in frequently encountered languages other than English.

[20]65 Fed. Reg. 50,121.

[21]It was beyond the scope of our work to conduct an exhaustive review of all CMS activities that may relate to elements of the plan. Our review focused on the written translation of documents.

Table 1: Elements of HHS's LEP Strategic Plan

Element	Element description
Assessment: needs and capacity	"Each agency, program, and activity of HHS will have in place mechanisms to assess, on a regular and consistent basis, the LEP status and language assistance needs of current and potential customers, as well as mechanisms to assess the agency's capacity to meet these needs according to the elements of this plan."
Oral language assistance services	"Each agency, program, and activity of HHS will arrange for the provision of oral language assistance in response to the needs of LEP customers, in both face-to-face and by telephone encounters."
Written translations	"Each agency, program, and activity of HHS will provide vital documents in languages other than English where a significant number or percentage of the customers served or eligible to be served has LEP. These written materials may include paper and electronic documents such as publications, notices, correspondence, web sites and signs."
Policies and procedures	"Each agency, program, and activity of HHS will have in place specific written policies and procedures related to each of the plan elements and designated staff who will be responsible for implementing activities related to these policies."
Notification of the availability of free language services	"Each agency, program, and activity of HHS will proactively inform LEP customers of the availability of free language assistance services through both oral and written notice, in his or her primary language."
Staff training	"Each agency, program, and activity of HHS will train front-line and managerial staff on the policies and procedures of its language assistance activities."
Assessing accessibility and quality	"Each agency, program, and activity of HHS will institute procedures to assess the accessibility and quality of language assistance activities for LEP customers."

Source: HHS LEP Strategic Plan.

In our December 2008 report on 1-800-MEDICARE, we reported that HHS officials said the language assistance plan provides a "road map" for addressing HHS's goals, while allowing individual operating divisions and agencies, including CMS, some flexibility in implementing the plan's requirements.[22] We also reported on shortcomings in CMS's implementation of HHS's language access plan, primarily the lack of a specific division or point person within the agency to manage the plan. Consequently, we recommended that CMS designate an official or office with responsibility for the LEP plan to ensure its offices are aware of, and take steps consistent with, HHS's Plan when considering the needs of people with LEP. In response to our recommendation, CMS appointed an individual in OEOCR and gave this person responsibility for developing an LEP plan specific to CMS.

CMS Translates Most Medicare Documents into Spanish, but Lacks an Agencywide Translation Policy

CMS components translated 117 (87 percent) of the 134 Medicare documents we identified into Spanish, including general educational materials and forms and notices specific to individual beneficiaries' coverage. In addition, one CMS component—the Office of External Affairs (OEA)—which supports all the components of the agency in their efforts to communicate with beneficiaries and the public about Medicare and other CMS-administered programs—translated a limited number of these documents

[22]GAO-09-104.

into other languages, such as Chinese, Korean, and Vietnamese. The remaining 17 documents we identified were only available in English. Responsibility for creating and translating most of these documents fell primarily under the purview of two CMS components, the OEA and the Center for Drug and Health Plan Choice (CPC) which oversees the MA-plans and the prescription drug benefit program. Table 2 provides information about the components responsible for the Medicare documents we identified and the number of translated documents. (Enclosure I provides additional information on these documents and their availability in languages other than English.)

Table 2: Translation of Medicare Documents by CMS Component

Medicare documents by component	Number of translated documents	Number of documents available only in English
Office of External Affairs' Creative Services Group	88	1
Center for Drug and Health Plan Choice	21	4
Other	8	12
Total	**117**	**17**

Source: GAO analysis of Medicare documents.

These translation efforts were undertaken despite the absence of an agencywide translation policy and lack of awareness internally of HHS's LEP plan. This plan indicates that HHS agencies, including CMS, will strive to implement specific written policies and procedures related to written translations for LEP individuals and designate staff who are responsible for activities related to these policies. As in the prior GAO report, which identified shortcomings in CMS's implementation of HHS's LEP plan, CMS officials we interviewed were unaware of any agencywide translation policies related to Medicare documents. Although CMS, in response to our recommendation, appointed an OEOCR official to develop an LEP plan specific to CMS, the plan is still under development and is not expected to be completed until fall 2009, according to a CMS official.[23]

Because CMS does not have an agencywide translation policy and only recently appointed an official responsible for developing a CMS-specific LEP plan, the extent to which Medicare documents were translated depended entirely on decisions made by individual CMS components. For example, the Creative Services Group (CSG), within CMS's OEA, was responsible for 89 of the 134 documents we identified and translated all but one of the documents (99 percent) it created into Spanish because it determined that it is the most common language spoken by LEP Medicare

[23]Since our report in December 2008, the OEOCR official responsible for developing the LEP plan has drafted a version of this plan using the HHS LEP plan as a model, consulted with the CMS component responsible for 1-800-MEDICARE about how they serve LEP beneficiaries, and spoken to external stakeholders to gain input on CMS's current approach to address LEP issues.

beneficiaries.[24, 25] CSG also translated 7 of these 89 documents into additional languages based on available resources, such as funding and qualified translators. CSG develops publications to educate beneficiaries about various aspects of the Medicare program and about specific health care issues.[26] For example, CSG develops *Medicare & You*, a handbook that is sent to all Medicare beneficiaries, which summarizes program benefits and beneficiaries' rights and protections and answers the most frequently asked questions about the program. Numerous other CSG publications, such as *Women and Heart Disease* and *Medicare Coverage of Diabetes and Supplies*, provide disease-specific health information or explain related Medicare coverage. CSG's documents are typically accessed via one of two CMS Web sites—www.cms.hhs.gov or www.medicare.gov—or by calling 1-800-MEDICARE.[27]

In addition, the Medicare Enrollment and Appeals Group (MEAG), as well as other groups within CMS's CPC, created 25 of the 134 documents we identified and translated 21 of these documents (84 percent) into Spanish. Similar to CSG, the CPC translates most materials it creates into Spanish because most Medicare LEP beneficiaries speak Spanish; however, the CPC does not always translate templated documents that require the addition of beneficiary-specific information. The CPC primarily creates these documents to help CMS, or the participating plans, communicate with beneficiaries about their specific drug or MA-plan's coverage. For example, the center's *Notice of Denial of Medical Coverage* informs beneficiaries that coverage of certain medical services has been denied, provides the reason for the denial, and describes the appeal process. Another form, *Loss of Deemed Status*, informs beneficiaries who previously were eligible for a subsidy to help pay for their Part D premiums that they no longer automatically qualify for this assistance. In addition to CSG and the CPC, four other CMS components translated an additional eight documents into Spanish, which provided a range of information to Medicare beneficiaries, including payment notices, consent forms for home visits, and general Medicare information; however, CMS officials we interviewed were generally not aware of the reasons for the decision to translate these documents into Spanish.

When compared to the documents that CMS translated, the 17 documents we identified that were not translated varied in terms of their content and how they were disseminated. For example, 4 of these documents are templated forms that require

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[24]CMS officials estimate that approximately 6 percent of Medicare beneficiaries speak Spanish as their primary language.

[25]According to CMS officials, CSG did not translate the publication—*Bringing Better Health Care to Indian Communities*—into Spanish because it was targeted to the Native American population, which made translating the publication into Spanish unnecessary.

[26]Although beyond the scope of our work, an OEA official indicated that the group also creates and translates press releases and other related information into Spanish, Chinese, Korean, and Vietnamese to better serve LEP Medicare beneficiaries.

[27]These documents can be found by accessing two of CMS's Web sites—www.medicare.gov or www.cms.hhs.gov. The www.medicare.gov Web site is designed to provide a variety of program information to Medicare beneficiaries, whereas www.cms.hhs.gov is a Web site that targets information to a broader audience, including health professionals and consumers, about the Medicare program, as well as other CMS programs such as Medicaid and the State Children's Health Insurance Program (CHIP).

health care providers to add specific information about a beneficiary's coverage, including 2 documents related to benefit exclusions or changes to a beneficiary's portion of costs and 2 documents that provide a beneficiary the opportunity to request information about their coverage.[28] These documents are typically provided directly to beneficiaries by their health care provider.[29, 30] Further, according to CMS officials, the CSG did not translate one publication into Spanish because the publication was targeted to the Native American population, which made translating the publication into Spanish unnecessary. CMS officials we interviewed were unaware of why the remaining 12 documents were not translated and provided several possible reasons why the documents may not have been translated, including not being able to identify the CMS component that originated the document. The majority of the remaining documents contain information about how to manage certain health conditions or the Medicare program—information similar to what is included in other documents that CMS translated into Spanish. Although the agency currently translates approximately 87 percent of the Medicare documents we identified into Spanish, without an agencywide policy, there is no guarantee that the agency can ensure that Medicare documents containing vital beneficiary information will consistently be translated in the future for various LEP beneficiaries.

Health Care Providers Face Challenges Communicating with LEP Beneficiaries, Including Translating Medicare and Other Documents

Under Title VI and implementing regulations, health care providers that receive federal financial assistance must take reasonable steps to ensure meaningful access by eligible LEP individuals to their services. In some circumstances a recipient may need to provide language assistance services, such as translating written documents or providing oral language interpreters, to comply with Title VI and its implementing regulations. However, some provider organizations and four health care providers that we spoke to report that they have encountered challenges to overcoming

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[28]For two of these documents, *Medicare Redetermination Request* and *Medicare Reconsideration Request*, beneficiaries can submit the related CMS form or a written request that must include certain information, such as the beneficiary's name, specific services and items for which the request is being made, and the date the services were rendered or items were received.

[29]During the course of our work, we also identified 16 model notices, which are documents CMS provides to MA-plans, PDPs, MA-PD plans, and health care providers with CMS-approved language. Model notices are sent to beneficiaries and may contain information about benefit exclusions or changes to a beneficiary's portion of costs. CMS considers these documents to be plan marketing materials, and therefore, CPC, which created the documents, typically does not translate them. If MA-plans, PDPs, MA-PD plans, or health care providers use the model notices provided by CMS, the material undergoes an expedited review process to determine if the marketing materials meet CMS's guidelines. MA-plans, PDPs, MA-PD plans, and health care providers can change CMS's suggested language and format if they include certain CMS-required elements.

[30]In some cases, sponsors of MA-plans, PDPs, and MA-PD plans may need to translate these documents for LEP beneficiaries to comply with Title VI and the implementing regulations. Independent of Title VI and the implementing regulations, sponsors of MA-plans, PDPs, and MA-PD plans should provide translation services to their LEP enrollees in accordance with Part C and D regulations and guidelines. For example, in areas with a significant non-English speaking population, sponsors of these plans should provide marketing materials in the language of these individuals. 42 C.F.R. §§ 422.112(a)(8), 423.2264(e). In addition, in accordance with CMS's Medicare Marketing Guidelines, MA plans, PDPs, and MA-PD plans should make marketing materials for beneficiaries available in any language that is the primary language of more than 10 percent of the population in the plan's service area.

language barriers and translating necessary documents. The majority of documents providers translate for their LEP patients are documents they have developed specifically for their patients—such as consent forms, discharge information documents, and patient education material—but health care providers and provider organizations also cite some challenges specific to translating Medicare documents created by CMS into languages other than English and Spanish. Although CMS has translated 117 of the 134 Medicare documents we identified into Spanish, three providers that we spoke with told us that they have needed to translate some Medicare documents into additional languages. For example, one provider—whose primary patient population is Native American and who encounters five Native American dialects—told us they translated some Part D benefit information and Advance Beneficiary Notifications. Another provider told us that rather than translate Medicare materials word for word, they created their own documents describing Medicare's drug benefit program to give to patients. In lieu of translating these documents, three health care providers we spoke to use bilingual staff or an interpreter to perform "sight translations"—reading the Medicare document to the beneficiary in their primary language—or use a variation, where the provider reads the document and an interpreter orally interprets what has been said. According to some translators we spoke to who had experience translating medical documents, translating any government document can be difficult because of words and terms specific to government and the frequent use of acronyms. Further, translators and one organization interested in LEP issues explained that words specific to the medical profession made translation difficult because some languages do not contain words that reflect the meaning of those terms.

Although CMS translated the majority of Medicare documents we identified into Spanish, provider organizations and advocates representing the LEP population told us it would be helpful for CMS to have more Medicare documents translated into additional languages. This would prevent multiple providers from translating the same documents, as well as reduce the need for bilingual staff or interpreters to do sight translations. Some health care provider organizations and organizations interested in LEP issues told us they approached CMS about translating Medicare documents into other languages but typically received little or no response from the agency. However, CMS officials told us that they had developed partnerships with several external stakeholder groups and, in collaboration with these groups, have translated documents into additional languages. For example, this collaboration resulted in CMS translating seven products into Asian languages—Chinese, Korean, and Vietnamese. In addition, CMS's new LEP official has met with external LEP organizations and heard a wide range of concerns about LEP issues, which the official is working to address in the development of CMS's LEP plan.

Although our review focused on the translation of Medicare documents, providers, provider organizations, and advocacy groups told us that health care providers face multiple challenges to communicating with LEP patients, such as the high cost of providing translation or interpretation services, keeping staff trained and apprised of policies for communicating with LEP patients, and difficulty identifying qualified translators and interpreters. In addition, some providers, provider organizations, and other groups we spoke to told us the costs associated with establishing a language program is one of the biggest challenges that providers face in serving LEP patients. According to two provider organizations and one advocacy organization, this

challenge may be particularly acute for smaller providers with more limited resources. However, when we asked the providers we spoke to what their total translation costs were, none were able to give us costs for translation services because they do not differentiate between the costs for translation and interpretation services or do not track these costs at all.[31] All four providers that we spoke to told us that they have bilingual staff that may translate documents or have an internal translation department. These translation costs may be absorbed into the salaries of employees. Some translators told us that translation costs are generally charged on a per-word basis and may range between 8 cents per word to 30 cents per word, but may vary based on various factors, such as a document's complexity, dialects, use of jargon and acronyms, and the time frame to complete the project. Further, one provider organization and some providers and other groups told us that communication between providers and LEP patients does not occur solely through translated forms. For example, providers must be able to communicate verbally with LEP patients, including Medicare beneficiaries, to discuss symptoms, explain instructions and tests, and describe diagnoses. To do this, providers have hired bilingual or multilingual staff, contracted with interpreters, or established language help lines.

Conclusions

While CMS has translated 87 percent of its Medicare documents into Spanish, the agency does not have an agencywide policy related to the translation of documents. We previously reported that CMS has not taken steps to ensure that officials throughout the agency are fully aware of the HHS LEP Plan and therefore lacks a key internal control measure—a clearly defined area of responsibility that has been communicated agencywide—by not identifying an official point of contact responsible for implementing HHS's LEP plan for CMS. CMS has since appointed an individual who has begun to develop an agencywide LEP plan and told us that it plans to address who will have responsibility for managing this plan. Although CMS told us that it plans to address translation in its LEP plan, this plan is still in development, and agency officials have not informed us of how their plan will address the translation of written materials at this time. CMS should have an agencywide policy that includes criteria for translating documents into languages other than English that is coordinated across its components to ensure translation decisions are made consistently. For example, such criteria should include assessing the language needs of current and potential beneficiaries. Without such a policy, CMS cannot ensure that Medicare documents containing vital information for beneficiaries will be consistently translated in the future for the various groups of LEP beneficiaries.

Recommendation for Executive Action

To improve the consistency and transparency of CMS's decisions to translate its documents into other languages, we recommend that the Administrator of the

[31]One health care provider we spoke to was able to provide aggregate costs for their language program, which includes bilingual staff and physicians, agency interpreters, telephonic language lines, and translation, but could not break out the costs for interpretation and translation. This provider told us that for fiscal year 2009, their total language costs were estimated to be $1.3 million of their total projected expenses of about $1 billion.

Centers for Medicare & Medicaid Services direct the appropriate CMS offices or LEP plan manager to include a written, agencywide policy for translation of written documents as part of its LEP plan. Such a policy should include criteria for translating documents, including assessing the language needs of current and potential beneficiaries, and a process for ensuring that the CMS office or individual responsible for managing the LEP plan has complete and accurate information about CMS's efforts to translate documents.

Agency Comments

We provided the Centers for Medicare & Medicaid Services a draft of this report for review and comment. In response to our draft report, CMS said that it has developed a draft LEP plan that will include an agencywide strategic policy that provides criteria to ensure Medicare documents produced by CMS with vital beneficiary information are consistently translated. However, agency officials declined to provide a copy to us, stating that it was still in development. CMS also noted that the agency ensures marketing materials used by MA organizations and PDP sponsors are translated for LEP Medicare beneficiaries by requiring, under its Marketing Guidelines, that these materials are provided by sponsors in alternative formats, including foreign languages. They also said that beneficiaries can request that their health plan send materials to them in a specific translated format. Further, CMS updated its Health Plan Management System, which collects and tracks Medicare health plan marketing materials. The updates will permit CMS to better track the marketing materials by allowing health plans to submit individually translated documents to the management system any time during the year, beginning in contract year 2010. CMS's written comments are reprinted in enclosure II. CMS and HHS also provided technical comments which we incorporated as appropriate.

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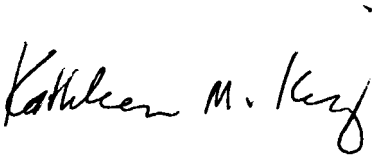
We are sending copies of this report to the Administrator of the Centers for Medicare & Medicaid Services, interested congressional committees, and other parties. In addition, the report will be available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov, or William B. Shear at (202) 512-8678 or shearw@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report were Susan Anthony, Assistant Director; Kay Kuhlman, Assistant Director; Tania Calhoun; Drew Long; Michaela M. Monaghan; Rhonda Rose; Sari B. Shuman; and Hemi Tewarson.

Sincerely yours,



Kathleen M. King
Director, Health Care

William B. Shear
Director, Financial Markets and
Community Investment

Enclosures (2)

Enclosure I: Availability of Medicare Documents

Table 3: Availability of Medicare Documents Translated into Spanish

	Title	Document number, when available	Web site[a]
Documents containing general health or Medicare information			
1	2009 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare	2110	Medicare
2	4 Ways to Help Lower Your Medicare Prescription Drug Costs	11417	Medicare
3	A Healthier US Starts Here	11308	Medicare
4	Are You Having Trouble Paying for Prescription Drugs?[b]	11318	Medicare
5	Are You Paying the Right Amount for Your Prescriptions?	11324	Medicare
6	Billing for Certain Injectable and Infused Medicare Part B Drugs	11148	Medicare
7	Bridging the Coverage Gap	11213	Medicare
8	Colorectal Cancer Basic Facts on Screening	11011	Medicare
9	Dialysis Facility Compare Tool at www.medicare.gov	10208	Medicare
10	Enrolling in Medicare[c]	11036	N/A
11	e-prescribing: Connecting to Better Healthcare	11382	Medicare
12	Get Your Medicare Questions Answered with 1-800-MEDICARE	11386	Medicare
13	Getting a Second Opinion Before Surgery	2173	Medicare
14	Getting Medical Care and Prescription Drugs in a Disaster or Emergency Area	11377	Medicare
15	Getting Medicare before you get your Full Social Security Retirement Benefits	11038	Medicare
16	Guide to Choosing a Nursing Home	2174	Medicare
17	Have You Done Your Yearly Medicare Enrollment Review?[b]	11220	Medicare
18	How Can Recovery Audit Contractors Help Me	11349	Medicare
19	How Medicare Covers Self Administered Drugs Given in Hospital Outpatient Settings	11333	Medicare
20	How Medicare Drug Plans Use Pharmacies, Formularies and Common Coverage Rules	11136	Medicare
21	How the Medicare Beneficiary Ombudsman Works For You	11173	Medicare
22	How to File a Medicare Part A or Part B Appeal in the Original Medicare Plan	11316	Medicare
23	Looking for a Doctor?	11383	Medicare
24	Marketing Rules for Medicare Private Fee-For-Service plans	11327	Medicare
25	Medicare and Your Mental Health Benefits	10184	Medicare
26	Medicare & You 2009	10050	Medicare
27	Medicare Advantage Plans and Medicare Cost Plans: How to File a Complaint (Grievance or Appeal)	11312	Medicare
28	Medicare and Ambulance Services	11398	Medicare
29	Medicare and Clinical Research Studies	2226	Medicare
30	Medicare and Home Health Care	10969	Medicare
31	Medicare and Hospice Benefits: Getting Started	11361	Medicare
32	Medicare and Other Health Benefits: Your Guide to Who Pays First	2179	Medicare
33	Medicare and Skilled Nursing Facility Care Benefits: Getting Started	11359	Medicare
34	Medicare and Your Mental Health Benefits: Getting Started	11358	Medicare

35	Medicare at a Glance[b]	11082	Medicare
36	Medicare Basics: A Guide for Families and Friends of People with Medicare	11034	Medicare
37	Medicare Coverage of Ambulance Services	11021	Medicare
38	Medicare Coverage of Diabetes Supplies & Services	11022	Medicare
39	Medicare Coverage of Durable Medical Equipment and Other Devices	11045	Medicare
40	Medicare Coverage of Kidney Dialysis and Kidney Transplant Services	10128	Medicare
41	Medicare Coverage of Skilled Nursing Facility Care	10153	Medicare
42	Medicare Coverage Outside of the United States	11037	Medicare
43	Medicare Hospice Benefits	2154	Medicare
44	Medicare Limits on Therapy Services	10988	Medicare
45	Medicare Physician Quality Reporting Initiative (PQRI) Letter	11317	Medicare
46	Medicare Prescription Drug Coverage: How to File a Grievance, Request a Coverage Determination, or File an Appeal[b]	11112	Medicare
47	Medicare Prescription Drug Coverage: How to Join a Medicare Drug Plan	11111	Medicare
48	Medicare Savings Programs	10126	Medicare
49	Medicare: Getting Started	11389	Medicare
50	Medicare's Coverage of Dialysis and Kidney Transplant Benefits: Getting Started	11360	Medicare
51	Medicare's Home Health Benefit: Getting Started	11357	Medicare
52	Medicare's Hospital Compare	11342	Medicare
53	Medicare's Nursing Home Compare	11385	Medicare
54	Medicare's Wheelchair and Scooter Benefit	11046	Medicare
55	My Medicines	11085	Medicare
56	MyMedicare.gov	11297	Medicare
57	New Rules for How Medicare Pays Suppliers for Oxygen Equipment	11405	Medicare
58	Personal Health Records	11397	Medicare
59	Planning for Your Discharge: A Checklist for Patients and Caregivers Preparing to Leave a Hospital, Nursing Home, or Other Health Care Setting	11376	Medicare
60	Preparing for Emergencies: A Guide for People on Dialysis	10150	Medicare
61	Protecting Medicare and You from Fraud	10111	Medicare
62	Protecting Your Health Insurance Coverage	10199	Medicare
63	Quick Facts about Medicare Prescription Drug Coverage and How to Protect Your Personal Information	11147	Medicare
64	Quick Facts about Medicare’s Coverage for Prescription Drugs	11102	Medicare
65	Quick Facts about Medicare’s Coverage for Prescription Drugs for People Who Have Prescription Coverage from an Employer or Union	11107	Medicare
66	Quick Facts about Medicare's Prescription Drug Coverage for People in a Medicare Advantage Plan or Medicare Cost Plan with Prescription Drug Coverage	11135	Medicare
67	Quick Facts About Paying for Outpatient Services for People with Medicare Part B	2118	Medicare
68	Quick Facts about Programs of All Inclusive Care for the Elderly (PACE)	11341	Medicare
69	Quick Tips for People with Medicare: Using Your New Medicare Drug Coverage	11343	Medicare

70	Staying Healthy—Medicare's Preventive Services[b]	11100	Medicare
71	Things to Think About When You Compare Medicare Drug Coverage	11163	Medicare
72	Use Information About Quality on Medicare.gov: Compare Plans and Providers	11266	Medicare
73	Welcome To Medicare[d]	11095	N/A
74	What are Long-Term Care Hospitals?	11347	Medicare
75	What is Medicare? What is Medicaid?[b]	11306	Medicare
76	What to Do If You No Longer Automatically Qualify for Extra Help with Medicare Prescription Drug Costs	11215	Medicare
77	What You Need to Know about Medicare Prescription Drug Coverage if You Have a Medigap Policy	11113	Medicare
78	Where to Get Your Medicare Questions Answered	2246	Medicare
79	Withholding Medicare Prescription Drug Premiums From Your 2009 Social Security Payment	11400	Medicare
80	Withholding Premiums From Your Social Security Payment	11200	Medicare
81	Women and Heart Disease: Things You Need to Know	11294	Medicare
82	Women with Medicare: Visiting Your Doctor for a Pap Test, Pelvic Exam, and Clinical Breast Exam	2248	Medicare
83	www.medicare.gov[b]	10108	Medicare
84	You Can Live: Your Guide for Living with Kidney Failure	2119	Medicare
85	Your Guide to Medicare Medical Savings Account Plans	11206	Medicare
86	Your Guide to Medicare Prescription Drug Coverage	11109	Medicare
87	Your Guide to Medicare Private Fee-for-Service Plans	10144	Medicare
88	Your Guide to Medicare Special Needs Plans (SNPs)	11302	Medicare
89	Your Guide to Medicare's Preferred Provider Organization (PPO) plans	11152	Medicare
90	Your Guide to Medicare's Preventive Services	10110	Medicare
91	Your Medicare Benefits	10116	Medicare
92	Your Medicare Rights and Protections[c]	10112	N/A
Documents containing information about Medicare Parts A and B			
93	Advanced Beneficiary Notice of Noncoverage (ABN)	CMS-R-131	CMS
94	Consent for Home Visit	CMS-36	CMS
95	Consent for Home Visit for PACE Services Evaluations	CMS-36 P	CMS
96	Detailed Explanation of Non-Coverage	CMS-10124	CMS
97	Home Health Advance Beneficiary Notice	CMS-R-296	CMS
98	Notice of Medicare Provider Non-Coverage	CMS-10123	CMS
99	Transfer (Assignment) of Appeal Rights[c]	CMS-20031	CMS
Documents containing information about Medicare Part C or Part D			
100	Detailed Explanation of Non-Coverage	CMS-10095 (DENC)	CMS
101	Medicare Prescription Drug Coverage & Your Rights	CMS-10147	CMS
102	Notice of Denial of Medical Coverage	CMS-10003	CMS
103	Notice of Denial of Medicare Prescription Drug Coverage	CMS-10146	CMS
104	Notice of Denial of Payment	CMS-10003-NDP	CMS
105	Notice of Medicare Non-Coverage	CMS-10095 (NOMNC)	CMS
Documents containing information about Medicare Parts A, B, C, or D			
106	An Important Message From Medicare About Your Rights	CMS-R-193	CMS
107	Appointment of Representative	CMS-1696	CMS
108	Detailed Notice of Discharge	CMS-10066	CMS
Documents containing information about Medicare's low-income subsidy			
109	Auto-Enrollment Notice	11154	CMS
110	Change in Extra Help Co-payment letter	11199	CMS

111	Facilitated Enrollment Notice: Full Subsidy Version	11186	CMS
112	Loss of Deemed (Extra Help) Status Notice	11198	CMS
113	Monthly Deemed Notice	11166	CMS
114	Re-assignment Notice: Plan Termination Version	11208	CMS
Documents containing other Medicare information			
115	1-800-MEDICARE Authorization to Disclose Personal Health Information[e]	CMS-10106	N/A
116	Notice of Medicare Premium Payment Due[e]	CMS-500	N/A
117	Patient's Request for Medicare Payment	CMS-1490S	CMS

Source: GAO analysis of Medicare documents.

[a]Medicare's Web site is www.medicare.gov; CMS's Web site is www.cms.hhs.gov.

[b]This publication is also available in Chinese, Korean, and Vietnamese.

[c]This document is translated into Spanish but is awaiting agency approval and cannot currently be located on the CMS or Medicare Web sites.

[d]CMS does not translate this document but provides an equivalent document in Spanish to beneficiaries in Puerto Rico.

[e]This form can only be found by contacting CMS or the Social Security Administration directly.

Table 4: Availability of English-Only Medicare Documents

	Title	Document number, when available
	Documents containing general health or Medicare information	
1	1-800-MEDICARE Billing Questions Fact Sheet	11365
2	Bringing Better Health Care to Indian Communities	11368-N
3	CRC (Colorectal Cancer) Screening Saves Lives	11010
4	Filing a Complaint Concerning Dialysis or Kidney Transplant Care	11314
5	Mammograms & Breast Health: An Information Guide for Women	11117
6	Medicare Health and Safety Standards: How to File a Complaint	11313
7	Medicare's Incentive Reward Program for Fraud and Abuse	99913
8	Pap Tests for Older Women	10149
9	Prostate Cancer Screening: A Decision Guide for Men with Medicare	11042
10	Quality of Care Concerns	11362
11	What to Do If You Have a Concern Regarding Care You Received While on Medicare	11348
	Documents containing information about Medicare Parts A or B	
12	Notice of Exclusions From Medicare Benefits - Skilled Nursing Facility (NEMB-SNF)	CMS-20014
13	FFS Skilled Nursing Facility Advance Beneficiary Notice	CMS-10055
14	Medicare Reconsideration Request Form	CMS-20033
15	Medicare Redetermination Request	CMS-20027
	Documents containing other Medicare information	
16	ESRD Beneficiary Selection Form	CMS-382
17	Financial Statement of Debtor	CMS-379

Source: GAO analysis of Medicare documents.

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JUL 21 2009

Kathleen M. King
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

William B. Shear
Director, Financial Markets and Community Investment
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. King and Mr. Shear:

Please find enclosed the comments of the U.S. Department of Health and Human Services, including the Office for Civil Rights and the Centers for Medicare & Medicaid Services, on the Government Accountability Office's (GAO) draft report entitled, "CMS Should Develop an Agency-wide Policy for Translating Medicare Documents into Languages Other Than English" (GAO-09-752R).

The Department appreciates the opportunity to review and comment before its publication.

Sincerely,

Barbara Pisaro Clark

Barbara Pisaro Clark
Acting Assistant Secretary for Legislation

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUL 16 2009

TO: Barbara Pisaro Clark
Assistant Secretary for Legislation

FROM: Charlene M. Frizzera
Acting Administrator

SUBJECT: Government Accountability Office (GAO) Draft Correspondence: "CMS Should Develop an Agency-wide Policy for Translating Medicare Documents into Languages other Than English" (GAO-09-752R)

Thank you for the opportunity to review and comment on the GAO Draft correspondence "CMS Should Develop an Agency-wide Policy for Translating Medicare Documents into Languages other Than English" (GAO-09-752R). In this draft correspondence, the GAO (1) examined the extent to which the Centers for Medicare & Medicaid Services (CMS) translates Medicare documents into languages other than English, and (2) describes the challenges health care providers may face in communicating with beneficiaries with limited English proficiency (LEP), including translating Medicare and other documents.

We appreciate the time and effort GAO put into reviewing our processes. We are pleased that GAO has acknowledged our efforts to develop an agency-wide translation policy. It is our goal to provide clear, accurate, and timely information about this program and to make the information accessible to beneficiaries and caregivers.

Below is our response to the draft GAO recommendation as well as additional comments.

GAO Recommendation

To improve the consistency and transparency of CMS' decisions to translate its documents into other languages, GAO recommends that CMS develop a written agency-wide policy for translation of written documents as part of its development of a LEP plan. Such a policy should include criteria for translating documents, including assessing the language needs of current and potential beneficiaries, and a process for ensuring that the CMS office or individual responsible for managing the LEP plan has complete and accurate information about CMS' efforts to translate documents.

CMS Response:

The CMS has prepared a draft "*Strategic Language Access Plan (LAP) to improve access to CMS programs and activities by Limited English Proficient (LEP) Persons.*" The plan will implement the agency-wide strategic policy that determines the criteria to use to ensure that Medicare documents produced by CMS that contain vital beneficiary information are consistently translated.

The CMS also ensures that marketing materials used by Medicare Advantage (MA) organizations and Prescription Drug Plan (PDP) sponsors are translated for beneficiaries with LEP by providing specific alternative format requirements in our Marketing Guidelines (e.g. foreign languages, as well as Braille, audio tapes, large print). Furthermore, beneficiaries can call their health plan at any time during the contract year and request their material be sent to them in a specific translated format. In addition, CMS has updated its Health Plan Management System (HPMS), which collects and tracks Medicare health plan marketing materials. For contract year (CY) 2010 HPMS will be able to better track translated marketing materials by allowing plans the ability to submit different individual translated materials at any time during the year.

The CMS will refine its Marketing Guidelines and the system for tracking plans' marketing materials as necessary to comply with the LAP which is currently under development.

Other Comments:

1. **Page 3:** There is a reference to the Office of External Affairs' (OEA) "Advanced Services Group" – there is no such group. We believe GAO is referring to OEA's Partner Relations Group.

2. **Pages 5 & 13:** CMS is concerned that when the author discusses the 1-800-MEDICARE study published in December 2008 (GAO-09-104), the author references shortcomings in CMS' LEP plan specific to 1-800-MEDICARE ("...a prior GAO report that identified shortcomings in CMS's implementation of HHS's LEP plan specific to 1-800 MEDICARE"). This reference is made on page 5 and page 13. This is misleading. The prior report did not identify shortcomings with 1-800-MEDICARE specific to LEP but rather to responsibility within CMS for the HHS LEP Plan. If the author is going to reference the report, the complete title should be used to eliminate confusion between 1-800-MEDICARE and the GAO report that has 1-800-MEDICARE in its title.

3. **Page 6:** The GAO report states that OEA and CPC—the two CMS components that translated the majority of the documents into Spanish—did so because it is the most common language spoken by LEP Medicare beneficiaries. The roughly 13 percent of documents that were not translated by CMS varied in terms of their content. Some were templates of forms and notices, which required MA plans or Part D PDPs to add beneficiary-specific information, including information related to benefit exclusions or changes to the beneficiary's portion of costs. CMS has marketing guidelines available at http://www.cms.hhs.gov/ManagedCareMarketing/03_FinalPartCMarketingGuidelines.asp#T

opOfPage that require organizations offering MA plans and PDPs to make marketing materials available to beneficiaries in any language that is the primary language of more than 10 percent of the population of the geographic area.

4. **Page 12:** GAO reported that "CMS components translated 119 (about 87 percent) of the 137 Medicare documents we identified into Spanish, including general educational materials and forms and notices specific to individual beneficiaries' coverage...The remaining 18 documents we identified were only available in English. Responsibility for creating and translating most of these documents fell primarily under the purview of two CMS components, the OEA, and the Center for Drug and Health Plan Choice (CPC), which oversees the Medicare Advantage program and the prescription drug benefit program." To ensure that beneficiaries enrolled in MA plans and PDPs have access to beneficiary education materials in alternative formats (e.g., Braille, foreign languages, audio tapes, large print), our Marketing Guidelines require organizations to provide a disclosure on pre-enrollment materials and the post-enrollment Evidence of Coverage (EOC), indicating the **document is available in alternative formats.**

5. **Page 13:** The author notes that OEA/Creative Services Group (CSG) was responsible for 89 out of 137 documents identified, and translated all but one. We suggest including the percentage translated (99%) in addition to the number, as is done with CPC on page 14. We would also like to note that the single document under OEA's responsibility that isn't translated into Spanish is one that is written specifically for a target audience of Native American beneficiaries, and requestors indicated that a Spanish version was not needed for this target audience in this case.

6. **Page 14:** Footnote 25 contains a reference to the State Children's Health Insurance Program. Drop "State" to indicate the current and accurate legal name for this program.

7. **Page 21, Table 2:** The following items listed in Table 2 of Enclosure 1currently include a footnote indicating that they are awaiting Spanish translation and CMS approval:
   a. Item 100 -- Detailed Explanation of Non-Coverage (CMS-10095 (DENC))
      - http://www.cms.hhs.gov/BNI/09_MAEDNotices.asp#TopOfPage
   b. Item 104 -- Notice of Denial of Medical Coverage (CMS-10003)
      - http://www.cms.hhs.gov/BNI/07_MADenialNotices.asp#TopOfPage
   c. Item 106 -- Notice of Denial of Payment (CMS-10003-NDP)
   d. Item 107 -- Notice of Medicare Non-Coverage (CMS-100095 (NOMNC))
      - http://www.cms.hhs.gov/BNI/09_MAEDNotices.asp#TopOfPage

   The Spanish translations for these notices have been completed and the notices are available on our Web pages. We recommend updating Table 2 by removing the footnote from these four notices and indicating that the Spanish translations are available on www.cms.hhs.gov.

Once again, we appreciate the efforts of the GAO and the professionalism exhibited by the staff responsible for this study. We are committed to improving our service wherever possible and will continue to work in partnership to keep you apprised as we implement the Report's recommendation.

(250410)