



November 9, 2015

Jocelyn Samuels  
Director  
Office for Civil Rights  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, D.C. 20201

Dear Director Samuels:

The Association of Asian Pacific Community Health Organizations (AAPCHO) appreciates the opportunity to comment on the Nondiscrimination in Health Programs and Activities proposed rule (RIN 0945-AA02).

AAPCHO supports strong and specific federal guidance to codify the nondiscrimination rights of all patients, including vulnerable Asian Americans, Native Hawaiians, and Other Pacific Islanders (AA & NHOPIs). As an Association of Community Health Centers supporting the needs of Asian American, Native Hawaiian, and Other Pacific Islanders, AAPCHO clinics see first-hand the impact of effective and appropriate in-language care. We support the essential rights of our membership to nondiscrimination on the basis of country of origin, which is integrally tied to access to in-language services. As safety-net clinics with large investments in culturally and linguistically appropriate services, we often encounter those who remain unconnected to their essential right to care by local health organizations.

AAPCHO would like to specifically highlight that we support the notice of rights to new enrollees going out in the 15 languages spoken by Limited English Proficient individuals by state, not nationally, to account for regional differences in language needs. Additionally, we would like to push for rules to codify the HHS LEP Guidance thresholds of 5% or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected in the covered entity's service area.

AAPCHO is a national not-for-profit association of 35 community-based health care organizations, 29 of which are Federally Qualified Health Centers (FQHC). AAPCHO members are dedicated to promoting advocacy, collaboration, and leadership to improve the health status and access of medically underserved AA&NHOPI in the U.S., its territories, and its freely associated states.

AAPCHO members focus on providing services that are uniquely appropriate to their patient populations including: comprehensive primary medical care, culturally and linguistically appropriate health care services, and non-clinical supportive enabling services such as interpretation and case management. On average, AAPCHO's health centers have a much higher rate of patients who are Limited English Proficient (LEP) (50% vs. 23%) with some health centers serving as many as 99% LEP individuals.

AAPCHO supports the comments submitted by the National Health Law Program and the Leadership Conference on Civil and Human Rights, particularly for the comments written on nondiscrimination in health-related insurance and other health-related coverage.

## Enforcement

We strongly support Section 1557's inclusion of both administrative and judicial remedies for discrimination. In particular, we recommend that the rule better reflect the statutory language by clarifying and strengthening the judicial enforcement opportunities and by directly recognizing that Section 1557 permits judicial claims for disparate impact discrimination. Further, as the statutory language of Section 1557 authorized the Secretary of HHS to promulgate regulations, we recommend the proposed rule apply to **all** federally funded, supported and conducted activities and not just those of HHS.

## § 92.4 Definitions

The proposed rules set out definitions of terms, including that of “Qualified Interpreter”, which is then used to determine who may assist entities with satisfying oral translation requirements. Therefore, the requirements and definition of “Qualified Interpreter” are essential to assure that the rule sections on interpretation are adequately assured.

We support the codification of the term “Qualified interpreter” and suggest that specific competencies need to be defined which would identify and designate individuals with the skills to serve as qualified interpreters. We find that defining the role of a qualified interpreter would reduce confusion over who could offer in-language services in the most effective manner, eliminating confusion in the clinical setting.

We support the Leadership Conference on Civil and Human Rights’ (hereafter referred to as “The Leadership Conference”) requests, that the interpreter could be considered competent and qualified if they have been nationally certified. We recognize that many competent community-based providers are not nationally certified, and yet remain able to serve as effective interpreters; therefore, if an interpreter is not nationally certified, the covered entity (defined as (1) An entity that operates a health program or activity, any part of which receives Federal financial assistance; (2) an entity established under Title I of the ACA that administers a health program or activity; and (3) the Department.) should do a competency-based assessment. Specifically, this assessment would capture the individual’s ability to:

1. Interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology and concepts, and/or
2. Demonstrate proficiency in, and has above average familiarity with speaking or understanding, both spoken English and at least one other spoken language; and is able, for an individual with limited English proficiency, to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary and context.

Additionally, we support The Leadership Conference’s recommendation to require HHS to state that using automated computer-based translation services does not meet the definition of a competent translation, and encourage HHS to define the role of “Qualified Translator.” We agree with and support the Leadership Conference’s request for further clarity in the final rule regarding the definition of sex discrimination as it applies to sex stereotypes, sexual orientation, and gender identity.

## § 92.5 Assurances Required

The proposed rule requires assurances for compliance with Section 1557 for all covered entities. This will involve submitting a form to the Director with a guarantee of compliance with Section 1557 requirements when applying for federal financial assistance. Since compliance with Section 1557 requirements inherently involves understanding the nature of the needs of the community served, we support requiring data collection as part of these assurances to fully demonstrate compliance with Section 1557. Covered entities should be required to collect data on race, ethnicity, language, sex, gender, gender identity, sexual orientation, disability status, country of origin, and age. An essential part of this data collection should include disaggregated data by ethnic group, to best assess the differing needs within broad racial and ethnic categories. Race and ethnicity categories should follow the categories outlined in Section 4302, rather than the aggregate OMB categories. In addition, data collection for race should include an open field for “Other Asian” and “Other Pacific Islander” to ensure the accuracy of self-reporting (e.g. if an Afghani checks “Other Asian,” or a Sri Lankan chooses “Asian Indian”).

We recommend that covered entities be required to assess the populations they serve and are eligible to serve, using the criteria listed above, on a regular basis. Proper data collection would ensure that entities can appropriately plan how to meet the needs of their clients and/or patients through data from their assessments. HHS needs to provide guidelines as to how to conduct an assessment, what data may be readily available, and how covered entities can access the data.

We support the Leadership Conference’s recommendations on defining the steps for covered entities to collect accurate data. That is, to:

- Train staff in collecting granular demographic data, including explaining why this data is being collected;
- Adopt clear privacy and nondiscrimination protections;
- Safeguard that patient/enrollee reporting of demographic data be voluntary; and
- Support analyses based on multiple demographic variables.

## § 92.7 Designation of Responsible Employee and Adoption of Grievance Procedures

The proposed § 92.7 specifically requires covered entities to designate an internal coordinator of compliance with Section 1557 standards and requires entities of a specific size to set up a grievance procedure. The proposed rule notes that OCR has observed both factors lead to better resolution of potential and actual concerns. We agree that the designation of specific employees and specific grievance procedures are essential to ensure efficient and effective organizational compliance with Section 1557.

The rule proposes that covered entities of 15 or more persons should designate one employee to oversee compliance of this rule. We agree and appreciate that this designation is consistent with the threshold of 15 persons for the Americans with Disabilities Act, and allows for both compliance efforts to be streamlined with one employee and allows smaller providers more flexibility with the use of their staff time.



Additionally, covered entities (of 15 or more) are required to adopt grievance procedures and due process standards. We thank the OCR for establishing this threshold and suggest that the regional HHS offices be charged with assisting organizations with understanding their responsibilities, offering examples of grievance procedures and due process standards and identifying and enforcing this provision with any organizations that fail to comply. We believe that regional HHS offices would have the best understanding of the entities in their areas that fall under the 15 or more employee category and a better understanding of effective procedures with the populations they serve. Regional offices are also more set up to take a hands-on approach should any organizations resist or delay set-up of grievance or due process standards.

### **§ 92.8 Notice Requirement**

The proposed rule requires covered entities to distribute a notice, described in § 92.8(a), which would inform new beneficiaries and enrollees about their rights, including their rights to language access services, free of charge and in a timely manner. We recognize how useful this information will be, and are concerned about members of our community not receiving this information in the language in which they are best served, potentially precluding individuals from accessing care when it is needed. As proposed, the rule states that this notice will be translated by the Director in the “top 15 languages spoken by individuals with limited English proficiency nationally.” However, we recommend that a more accurate requirement would be to make available the notices in the top 15 languages for individuals with limited English proficiency within each state, without basing the rule on national LEP population statistics.

State data gives a more accurate picture of the language needs by limited English proficient communities. For example, in Washington, the top 15 languages spoken by limited English proficient individuals would include 4 languages (Cambodian, Laotian, Hindi and Thai,) that are not part of the top 15 languages nationally. Hmong is one of the top 15 languages spoken by individuals with limited English proficiency in California, accounting for approximately 33,000 individuals, but is not in the top 15 nationally. Similarly, in New Jersey, Gujarati is one of the top 15 languages spoken by individuals with limited English proficiency in the state, representing approximately 30,000 individuals, but not nationally. If the top 15 limited English proficient languages are assessed only nationally, Hmong and Gujarati would not be included and these communities would be without in-language notices.

The proposed regulations codify the HHS LEP guidance stating that covered entities should include taglines on vital documents to inform LEP individuals of their rights to translation services and access to a language line. We suggest that taglines should be added to any important – “significant” or “vital”- publications or communications for beneficiaries, enrollees, or members of the public. These should be placed in a conspicuous location at the beginning of publications and communications to allow Limited English Persons (LEPs) to have an immediate reference for their language access rights. Significant or vital information includes: Summary of benefits and coverage, explanation of benefits, providers lists, outreach publications, terminations, change in status, appeals and anything related to eligibility.



## § 92.201 Meaningful Access For Individuals With Limited English Proficiency

### Restricted Use of Certain Persons To Interpret or Facilitate Communication § 92.201(e)

The proposed rule codifies standards set forth in the HHS LEP guidance, namely restrictions on using friends, family members or children for translation services. We strongly agree with these standards as and agree that such provisions are necessary to prevent issues of competency, confidentiality, privacy, and conflict of interest that arise as a result of relying on an informal interpreter.

#### Alternative Approaches

The proposed regulations do not incorporate specific thresholds for written translation, which runs counter to the existing HHS LEP guidelines. Not having a standard guideline effectively weakens these current mandatory minimums and safe harbor provisions. We strongly recommend that these rules codify the HHS LEP Guidance thresholds of 5% or 1,000, whichever is less, of the population of persons eligible to be served or likely to be affected in the covered entity's service area.

#### Conclusion

The communities that we serve deserve access to care and provision of resources in a timely and equitable manner, and we thank the OCR for its continued work in this regard. Many of these provisions are essential to set a standard for service to our communities, and set a standard for both civil rights and access to health care in America. We look forward to strong work going forward to ensure that these regulations are robust and enforcement remains effective to ensure access for everyone. For any questions, contact Heather Skrabak at [hskrabak@aapcho.org](mailto:hskrabak@aapcho.org) or (440) 409-7499.