

NCIHC Comments on HHS (comments from pull-down menu on Call for Comments on changes to 1557 7/17/2019)

- Whether, and if so how, the proposed rule addresses clarity and confusion over compliance requirements and rights of protected classes.

“I haven’t seen any reason to believe that this will only have a negligible impact,” said Mara Youdelman, managing attorney for the Washington, D.C. office of the National Health Law Program (NHeLP), a civil rights advocacy group. She told NBC News the proposal “will likely result in people just not knowing their rights (and) not accessing health care.”

An estimated 25 million people in the U.S. are limited English proficient (LEP), according to the Census Bureau. This means they are entitled to language assistance when seeking health care under Section 1557. Patients facing language barriers have a higher risk of health care complications because they may misunderstand a doctor’s instructions.

A statement on NHeLP’s website reads, “Opening the door to discrimination in our healthcare system is no way to ensure equal access to vital healthcare coverage or to plan for our country’s future. We should be building on the progress we made in the Affordable Care Act (ACA) in making health care available to more people; in ensuring that LEP individuals can understand their healthcare options; and in specifically prohibiting healthcare discrimination on the basis of race, ethnicity, immigration status, (or) disability. This administration is doing exactly the opposite.”

“(If the proposal is adopted) more patients would not understand information involving their health,” Katie Keith, a Georgetown University professor who specializes in the ACA, told NBC News. “Some of these details on insurance and billing documents are already difficult for native English speakers to decipher and could be a challenge for less fluent people.”

Under the 2016 rule, the word “qualified” was added with a definition to describe the requirements interpreters and translators must meet. This was a change from previous legislation that used the term “competent.” The new revisions propose to remove the word “qualified” but leave the definitions intact.

- Whether the Final Rule’s grievance procedures have achieved any significant mitigation of the costs of litigation over the new requirements created by the Final Rule.

Legal action

Under the 2016 rule, individuals can pursue legal action against the covered entity if they failed to provide the individual with proper language assistance. The new rule would reverse this provision, and “the Department would no longer take a position on that issue in its regulations, leaving the matter as primarily one for the courts to decide.”

- Whether, and if so, how new and developing technologies can assist covered entities with their compliance obligations and enhance access to quality health care.

Video remote interpreting (VRI) standards

Currently under Section 1557, VRI for LEP individuals must comply with the standards set forth by the ADA that state the covered entity must use high-quality, real-time video that does not lag, is not choppy, and is not grainy; voices must be clear and audible; there needs to be a “dedicated high-speed, wide-bandwidth video connection or wireless connection”; images need to be sharply delineated and both the interpreter’s and patient’s hands, fingers, arms, and face need to be visible; and adequate training needs

to be provided to staff using VRI equipment and services. Proposed revisions include repealing the visual standards but keeping the audio standards for remote interpretation (“clear, audible transmission of voices; use of quality video connection without lagging or irregular pauses in transmission; and applicable training for staff to use the remote interpreting technology”).

It’s important to note that the VRI standards will not change for individuals with communication needs protected under the ADA; this change is only applicable to LEP individuals.

The HHS document qualifies that “the proposed rule retains these access standards for persons who are deaf or hard of hearing” which is another epic source of disparities considering there is not equal access for LEP patients. The HHS would be creating a lack of standards for LEP patients while maintain said standard for the deaf and hard of hearing, furthering disparities in healthcare and language access.

- The costs incurred for design of health benefits, with any detailed information facts, surveys, audits, or reports.

The HHS clearly states that their main purpose for moving forward with the cuts in all areas is for budgetary reasons. However, this move only shifts the federal budgetary shortfalls to the state and regional levels, a move that would eventually have a domino effect back to the federal level.

- The costs to provide nondiscrimination notices and taglines, specifically including the marginal labor, material, postage, and depreciation costs for printing and mailing additional sides and sheets of paper (including extra postage), the volume of such notices.

HHS has projected that the revisions will save an estimated \$3.6 billion over the first five-year period after the regulations are finalized, a large portion of which will come from stripping the mandatory notices (i.e., taglines and non-discrimination policies) requirement. HHS has also said the new provisions will ease any burden placed on covered entities and eliminate any redundancies to already established laws.

*This HHS-approved document is being submitted to the Office of the Federal Register (OFR) for publication and has not yet been placed on public display or published in the Federal Register. This document may vary slightly from the published document if minor editorial changes are made during the OFR review process. The document published in the Federal Register is the official HHS-approved document.

*Individuals using assistive technology may not be able to fully access information in this document. For assistance, please contact the Office for Civil Rights at (800) 368-1019 or (800) 537-7697 (TDD) or mailings, and the impact of such notices or mailings on the utilization of language access services with any detailed supporting information, facts, surveys, audits, or reports;

- The prevalence of health care entities that operate and beneficiaries that reside in more than one State, with any detailed supporting information, facts, surveys, audits, or reports.

- The amount of marketing, enrollment, and benefits communications delivered or mailed per year, with any detailed supporting information, facts, surveys, audits, or reports.

- Unaddressed discrimination on the basis of race, color, national, and origin, sex, disability, and age as applied to State and Federally-facilitated Exchanges, with any detailed supporting information, facts, surveys, audits, or reports.

The standard for meaningful access evolved from Title VI of the Civil Rights Act of 1964 and its prohibition against discrimination on the basis of national origin. In 2000, Executive Order 13166 strengthened Title VI protections with the goal of improving access to government services for persons who were limited English proficient due to their nation of origin.

How Far Reaching? What Organizations Must Comply?

EO 13166 applies directly to federal agencies and recipients of federal funding. Considering how federal funds flow into government agencies at all levels, as well as non-profits and other organizations, EO 13166 affects thousands of organizations. These organizations offer programs and services in countless fields, including social services, health care, public safety, education, justice, transportation, housing, and more.

Identifying “Meaningful Access”

EO 13166 requires organizations to assess the services they offer, determine which of those services may be needed by LEP persons, and then develop a system to provide “meaningful access” without unduly burdening the agency. As a starting point, the U.S. Department of Justice’s “four-factor analysis” provides a self-assessment structure:

Demographics: The number or proportion of the LEP population eligible to be served or likely to be encountered;

Frequency of Contact: The regularity with which LEP individuals interact with the organization/program;

Nature: The importance of the program/service/activity to peoples’ lives;

Availability of resources and costs: The balance between achieving meaningful access without creating excessive financial burdens on the organization.

INFOGRAPHIC: How language access enhances understanding, maximizes efficiency, and creates a more positive public image

This four-factor analysis forces organizations to more fully understand the diverse populations they serve, as well as to assess their existing bilingual-staff resources.

Additionally, the nature of the organization’s services, and the importance of its work to peoples’ lives, dictates the speed and skill level required to communicate with LEP individuals.

When questions of health, safety, or legal rights are at stake, the consequences of not having a competent language solution in place can be serious — for the LEP person and the organization.

The Path to Meaningful Access

First-generation language access plans are often marginal, as organizations typically begin the process with limited information or history. It takes time and organization-wide collaboration for plans to evolve.

Fortunately, agencies that are now developing or updating their language access plans have a wealth of guidance from which to draw. There are abundant examples of resourceful and creative plans that combine community input, internal language resources, and coordinated management. The best approaches maximize an organization’s own internal bilingual resources and pull in professional language solutions when needed, while balancing budget and community considerations.

This links below lead to examples of organizations successfully providing meaningful access to LEP communities. This really is a fluid process that must evolve over time to meet the organization's mission and keep up with demographic changes.

- Whether covered entities seek guidance on best practices for compliance with Section 1557, such as for civil rights assurances signed by recipients of Federal financial assistance, and notices of civil rights posted in areas such as employee break rooms.
- The costs of coming into compliance or remaining in compliance with a Federal prohibition of discrimination on the basis of gender identity or sexual orientation under Title IX, and with any detailed supporting information, facts, surveys, audits, or reports.

Some cities have prepared extensive metrics on how they have complied with the current federal prohibition of discrimination. An example of such is the city of San Francisco, where one out of three residents is an immigrant. Based on numbers as seen in their 2018 report, 882,681 or 21.2% of the LEP patients needed language access services in San Francisco alone. This success story also highlights best practices, one of which is the use of taglines and multilingual notices made visible as well as translated materials. While these costs may have been high, the results are long lasting and allows an entity to track their healthcare system, which includes all individuals. The use of aggregated data allows them to project future needs as well as to assure they are in compliance with federal laws on language access. Their exemplary model of community outreach and input from the LEP population they serve has been particularly effective especially in the state of California which has undergone numerous crisis and emergency situations, from flooding, fires and potential earthquake disasters where language access protocols are essential to reach everyone. <https://sfgov.org/oceia/lao-annual-compliance-reports>

- Whether the proposed LEP provisions are practical, effective, fiscally responsible, reasonable, responsive to the particular circumstances relevant to health care programs or activities, and capable of being readily implemented.

The HHS has failed to recognize that while English is the primary language of a large portion of the U.S. population, one in three individuals does not speak English at home, and rather than decreasing in LEP population, it is increasing. There is a substantial growth in an emerging non-English population that as current demographics show, will continue to rise regardless of the current administration's non-research based projections have exposed. Nowhere in their report of budget cuts are there any numbers indicated people being impacted. The report shifts the need to implement changes based on discriminatory budget cuts and financial reasons rather than needs-based reasons. The world atlas of languages spoken at home <https://statisticalatlas.com/United-States/Languages> shows that English is the number one language, but that more than 30% of the U.S. population is foreign born and do not speak English as their primary language at home. The share of non-English speakers has been rising steadily for more than three decades. U.S. residents today are nearly twice as likely to speak a language other than English at home as residents in 1980, for instance. The census doesn't have as much long-term data on the percent of adult citizens speaking something other than English, but since 2009 it has been rising in tandem with the share of all resident non-English. In 39 U.S. counties, a majority of adult citizens speak a language other than English at home. speakers. https://www.washingtonpost.com/news/work/wp/2018/05/21/millions-of-u-s-citizens-dont-speak-english-to-each-other-thats-not-a-problem/?utm_term=.80fe4cf2a358

One of the requirements for becoming a U.S. citizen is that you are able to show U.S. Citizenship and Immigration Services (USCIS) that you can read, speak, and write **basic** English. [emphasis by author]. However, knowledge of English is waived if an individual is 50 years old or older and has lived in the U.S. as a permanent resident for at least 20 years, or 55 years old or older and you've lived in the U.S. as a permanent resident for at least 15 years.

<https://www.lawyers.com/legal-info/immigration/citizenship/english-and-civics-requirements-for-naturalization.html>

Approximately 32 million adults in the United States can't read, according to the U.S. Department of Education and the National Institute of Literacy. The Organization for Economic Cooperation and Development found that 50 percent of U.S. adults can't read a book written at an eighth-grade level. This means that these individuals have a limited ability to obtain and understand essential information; the unemployment rate is 2–4 times higher among those with little schooling than among those with Bachelor's degrees; they have lower income and lower-quality jobs, and most importantly, that it can impact their health-- Illiterate individuals have more workplace accidents, take longer to recover and more often misuse medication through ignorance of health care resources and because they have trouble reading and understanding the relevant information (warnings, dosage, contraindications, etc.). https://www.washingtonpost.com/news/answer-sheet/wp/2016/11/01/hiding-in-plain-sight-the-adult-literacy-crisis/?utm_term=.f0968540c09b

The Plain English Movement has arisen from this (https://ir.lawnet.fordham.edu/cgi/viewcontent.cgi?article=1475&context=faculty_scholarship), an effort stated in the legal field in 1981 to assure “to put everyone equal in a court of justice.” This movement has since moved into other fields, in particular in healthcare. As a result, there has been mandated efforts for changes in prescription drug labels and accompanying explanations based on demographics. The drug industry itself has been under scrutiny and attack because of its rising costs in medications, making them inaccessible to the average consumer. While the 2017 efforts to abolish the Affordable Care Act came up against court ordered resistance, the drug industry remains unscathed by their efforts to continue controlling prices and access (<https://www.healthaffairs.org/doi/10.1377/hblog20190103.183538/full/>) basically due to an inaction by Congress on drug law policy.

Combined together, the potential changes in the HHS policy regarding language access and lack of controls in the drug industry will be the bombshell that creates a public health crisis in the United States, not just in the LEP, deaf and hard of hearing and LGBTQ populations, but in the entire populations. Changes made for monetary and budgetary reasons are shortsighted in seeing the overall impact of outbreaks in diseases, heightened burdens on the government for those who suffer chronic illnesses, and potential cut-backs on the needed research that could prevent and contain healthcare needs.

While the U.S. proports itself to be one of the most advanced nations in health care, changes in language access will impact overall patient safety and quality of health care. The need for Culturally and Linguistically Appropriate Services (CLAS) and strong Language Access Plans has never been higher. While some refer to the lack of health care provided is based on “language barriers,” the government is now becoming the barrier to provision of quality patient care and creating an overwhelming potential risk management situation for healthcare providers. As Chen Wilson explains in the article, “Patient Safety and Healthcare Quality: The Case for Language Access.” *Int J Health Policy Manag.* 2013 Nov; 1(4): 251–253, (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3937896/>) a lack of concordance between patient-provider communication creates a situation where a patient's health care is compromised. HHS needs to decide if the humanitarian road is more important than the exclusive road they are pursuing.

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Section 1557 compliance coordinator

The new rule proposes to eliminate the requirement for covered entities with 15 or more employees to designate a compliance coordinator and have a written grievance procedure in place.

- Whether HHS's Title VI regulations at 45 CFR Part 80 should be amended to address the *Lau v. Nichols* precedent applicable to LEP individuals under any program or activity receiving Federal financial assistance from HHS.
- Whether HHS's Section 504 regulations at 45 CFR Part 85 should be amended to address effective communication, accessibility standards for buildings of facilities, accessibility of electronic information technology, and the requirement to make reasonable modifications for otherwise qualified individuals with disabilities under any program or activity receiving Federal financial assistance from HHS; and
- Whether the proposed provisions on language assistance services adequately balance an LEP individual's meaningful access to effectively participate in the covered health program or activity with the resources available and costs to the covered entity.

While having a formal language access plan is not specifically required under the current iteration of Section 1557, it is something the Office for Civil Rights considers when evaluating a covered entity for compliance. Mention of language access plans will be stricken under the proposed rule, and whether the covered entity has developed and implemented such a plan will no longer be a consideration when evaluating compliance.