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U.S. Department of Health and Human Services
Office for Civil Rights
Submitted electronically to http://www.regulations.gov
ATTN: 1557 NPRM (RIN 0945-AA02)

To whom it may concern:
These comments are submitted by the Massachusetts Law Reform Institute, a state-wide poverty law and policy center whose mission is to advance economic, racial and social justice through legal action, education and advocacy.

We strongly support the proposed rule's nondiscrimination protections in all federally funded, supported and conducted health programs and activities. Discrimination in health coverage is insidious. The Rev. Martin Luther King said it best, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." We strongly support the rule's prohibition on discrimination on the basis of race, color, national origin (including immigration status and language), sex (including sex stereotyping and gender identity), disability, sex and age.

Language Access:
Massachusetts is home to the 8th largest population of limited English proficient (LEP) persons in the United States, with approximately 550,000 residents (nearly 9 percent of the population) speaking English "less than very well." Therefore, we strongly support the rule's specific requirements to ensure meaningful access for individuals with limited English proficiency, and the proposal to clarify and codify existing nondiscrimination requirements regarding language access under § 92.2.

Section 92.2 details that language assistance services include oral language assistance, written translation, and taglines, while § 92.4 only defines the qualifications of the oral interpreter. While we strongly support the definition of qualified interpreter under § 92.4, we suggest including a definition of a qualified written translator as well. The detailed criteria are essential so that entities can understand, in clear and unambiguous terms, the qualifications required for all professionals providing language access translation and interpretation. Specific standards could help entities understand their requirements and determine in objective terms whether they are in compliance with program requirements.

It is not clear from the proposed wording whether the second requirement under § 92.201 is changing the requirements in the current four-part balancing test for determining language assistance services. We support the Director taking into account other relevant factors, and giving substantial weight "to the nature and importance of a particular health program" in order to provide the relevant communication needed to ensure access. In particular, we are

encouraged that under § 92.201 (b) (2) the Director will be required to give substantial weight to the "length, complexity and context" of the communication in a particular case, and provide the opportunity for an LEP individual to refer back to this oral information through a written document or an audio file. We would like to highlight that this Guidance does not prohibit entities from providing the required translations through computer generated translation programs. While these programs are helpful for informal context, they are fraught with issues, including incoherent or inexact translations. We have witnessed first-hand a situation where a computer translator used the term "hotel accommodation" in lieu of "disability accommodation." We request that the final rule specifically prohibit the use of computer-generated translators as a mean to translate any vital or significant documents. In terms of the definition of "timely," HHS should also clarify the remedy when undue delay providing translated materials prevents equal access, for example, when translated notice of appeal rights arrives after the appeal deadline. In such situations an extended period must be provided to afford participants their rights.

We also support the § 92.201 prohibition on covered entities requiring LEP persons to supply their own interpreter, or relying on a minor for interpretation. In response to HHS's request for comments on this subject, we urge HHS to also include in §92.201 specific thresholds for translating written documents as well, to ensure minimum standards exist. Additionally, we disagree that it is too onerous to propose that all covered entities have the capacity to provide, in their health programs or activities, qualified oral interpreters through telephonic interpretation services. As explained further in the proposed rules, most entities have the capacity to provide individuals with qualified telephonic interpreters, given the widespread commercial availability of this service.

Under the Alternative Approaches, we believe that covered entities, such as hospitals, nursing homes, skilled nursing facilities, home health agencies and retail pharmacies should have enhanced obligations to provide language assistance services. Institutions and retail chains that employ 15 or more persons should provide translation of all vital and significant documents and interpretation services for the top 15 languages in the state or region, as well as telephonic interpretation for all other languages. Additionally, these organizations should have requirements to have language-accessible websites, and to create and actively implement a language access plan.

In the notice requirements in § 92.8, we support requirements regarding free language assistance services and taglines. We strongly support that all notices adversely affecting clients provide information on how to file a complaint with OCR and include OCR contact information. Some state programs are moving away from providing administrative support in person, it is therefore important that all clients have access to OCR information through other means, the easiest of which is to have it included with other mailed notices. We also support that the notice providing information on how to file a complaint with OCR, as detailed in § 92.7(a)(7), be provided in the top 15 languages of their state/service area, rather than the top 15 national languages. The top 15 languages nationally will exclude significant languages in Massachusetts such as Mon-Khmer, Cambodian. The OCR notice should be allowed to be modified to be

appropriate for all communications where space is an issue, but regulations should require it rather than encourage it.

In terms of the posting of notices, §92.8(f) we do not agree with the proposed approach to only encourage, but not require, to post one or more of the translated notices in the most prevalent languages spoken by limited English proficient communities. We agree with the proposal that notices be posted in the most prevalent non-English languages encountered by covered entities in their geographic areas. We agree that this requirement would greatly improve access to the information in the notice to many underserved communities, especially in service areas where covered entities are not currently in full compliance with language access requirements under Title VI.

We do not oppose the tagline on Appendix B but we feel that it can have simpler wording to communicate the available assistance. "If you do not understand English we can provide help in [insert language], free of charge. Contact 1xx-xxx-xxxx." We also strongly agree that website taglines and links to other languages need to be conspicuously placed and "in language."

Covered entities: The preamble explaining the definition of covered entity in §92.4 states that Medicare Part B providers are not covered under Section 1557 (54194-5). We oppose this interpretation as inconsistent with the language and purpose of the law.

Sex Discrimination: We support the rule's new prohibitions on discrimination on the basis of sex and the rule's inclusion of sex stereotyping and gender identity in the definition of discrimination "on the basis of sex" in §92.4. As proud residents of the state that early on recognized the right of same sex couples to marry, we strongly urge HHS to prohibit discrimination based on sexual orientation as well.

In response to HHS's request for comments on this subject (54,173), we strongly oppose any new exemption that would permit discrimination based on religious views against any person, especially women, people with disabilities, or LGBT people. Neither statutory nor legislative history supports adding a religious refusal to § 1557, and the only exceptions to § 1557's broad nondiscrimination mandate are specifically and explicitly contained in Title I of the ACA. We strongly encourages HHS to enact a final rule that has no religious exemption to the sex discrimination provision, makes clear that health care refusals involving reproductive health care constitute impermissible sex discrimination, and contains an affirmative right to access medical information.

Disability Issues: We strongly support the provisions requiring effective communication for individuals with disabilities and accessibility standards, including the requirements for websites and electronic and information technology. However, in § 92.203 regarding accessibility standards for buildings and facilities, compliance should not be delayed. We also recommend the rule require basic accessibility for medical diagnostic equipment now while recognizing more specific standards from The Access Board will be provided at a later date. We commend the provision on reasonable accommodation for people with disabilities in § 92.205 but urge

HHS to provide examples of the kinds of programmatic discrimination that are necessary to avoid discrimination as outlined, for example, by the Disability Rights Education and Defense Fund (DREDF) in this 2007 paper, http://dredf.org/healthcare/Healthcarepgmaccess.pdf

Data Collection: We urge HHS to add a new section on data to the assurances required by §92.5. Strong data collection is necessary to comply with nondiscrimination requirements. Having accurate data ensures that covered entities have the needed information to determine how to provide language services and auxiliary aids and services. We urge HHS to add specific demographic data collection requirements to the rule for all covered entities. Covered entities should be required to collect data on race, ethnicity, language, sex, gender, gender identity, sexual orientation, disability status, and age. Beneficiaries must also be assured that supplying this information is voluntary and that the privacy of the information will be protected. Further, covered entities should be required to assess (and update their assessments) of the population they serve and are eligible to be served so that they can appropriately plan how to meet the needs of their clients/patients. HHS should provide guidelines as to how to conduct an assessment and what data may be readily available to covered entities.

Benefit Design and Marketing: We also strongly support nondiscrimination requirements to benefit design and marketing practices in §92.207. However, we urge HHS to define benefit design, as well as marketing practices and materials, to better clarify that § 1557's non-discrimination protections apply to the full scope of health programs and activities. We recommend HHS define "benefit design" to include, at a minimum, cost-sharing, formulary tiers, provider networks, limits on coverage of certain services by age or condition, prior authorization and other utilization management. As an example, health plans should not be permitted to put all the medications required to treat a condition or ailment on the highest formulary tier. If they do, they should be subject to Section 1557's enforcement provisions.

Enforcement: We strongly support Section 1557's inclusion of both administrative and judicial remedies for discrimination in §92.301-92.303. However, 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. Disparate impact claims are allowed under the civil rights statutes referenced by Section 1557. It is important that the 1557 regulations should explicitly protect against disparate impact discrimination.

We are grateful for the important protections HHS has proposed rules and the opportunity to comment on how they could be strengthened.

Signed,

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