November 2, 2015

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: 1557 NPRM (RIN 0945-AA02)
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW.,
Washington, DC 20201

U.S. Department of Health and Human Services Office for Civil Rights, Notice of proposed rulemaking Nondiscrimination in Health Programs and Activities, 46 CFR Part 92, RIN 0945-AA02

The American Dental Association (“ADA”) strongly supports nondiscrimination in health care and equal access to health care for all patients without regard to race, color, national origin, sex, age, religion or disability. Discrimination in health programs or activities receiving Federal financial assistance (“FFA”) is prohibited under §1557 of the Affordable Care Act¹ (“§1557” or “the statute”). Proposed rules under §1557 have been developed by the Office for Civil Rights (“OCR”) of the U.S. Department of Health and Human Services (“HHS”). The ADA believes that the proposed rules are confusing, duplicative and burdensome, as well as unnecessary. In addition, ADA is concerned that the proposed rules risk limiting patient access to care, particularly in impoverished communities, because health care providers may hesitate to accept the extra compliance burdens and liability risks that the proposed rule would impose on providers who participate in government health care programs.

The statute generally provides that an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving FFA, on the grounds of race, color, national origin, sex, age, or disability (but not religion). The statute is already in effect, and OCR is already enforcing the statute. Regulations are not required to implement the statute: section (c) of the statute states that the Secretary of the U.S. Department of Health and Human Services may promulgate regulations to implement §1557, but the statute does not require the promulgation of regulations, nor set a deadline for the development or implementation of regulations. The ADA urges OCR to simply enforce §1557 as written, without the promulgation of regulations.

OCR states in the preamble to the proposed rule that the regulation is necessary because one of the central aims of the Affordable Care Act is to expand access to health care and health coverage for all individuals. ADA urges OCR to delay the development of any final rule under §1557 until HHS has determined whether barriers to access are truly due to

¹ 42 U.S.C. 18116 §1557
discrimination, or if other causes, such as insufficient reimbursement and coverage under Medicaid and CHIP or lack of health literacy, are the real impediments to access.

ADA suggests that a more effective way to promote meaningful access to care for individuals of every race, color, national origin, sex, age, and disability, would be for HHS to (1) ensure network adequacy in all geographic locations through increases in Medicaid and CHIP reimbursement and to require states to expand Medicaid dental coverage for adults; (2) encourage and facilitate minority enrollment in professional programs to ensure an adequate number of providers with linguistic and cultural diversity, and (3) reduce the regulatory burden on health care providers, particularly small practices, to enable health care providers to focus their resources on patient care rather than compliance with and risk management of unproductive and confusing regulations.

1. Harmonization

In the preamble to the proposed rule, OCR states that it considered harmonizing each of the specific discriminatory actions prohibited across each civil rights law addressed by §1557, which could reduce redundancy but would likely lead to confusion and unintended differences in interpretation. ADA agrees with OCR that redundancy, confusion, and unintended differences in interpretation are predictable unintended consequences of §1557 enforcement. ADA urges OCR to exempt from §1557 enforcement of any health programs and activities to the extent that they are already covered by any applicable nondiscrimination requirements for that class of individuals under any federal, state or local law.

2. Scope

By its terms, §1557 applies to health programs and activities, if any part of the health program or activity is receiving FFA, as well as to health programs or any program or activity that is administered by an Executive Agency or any entity established under Title I of the Affordable Care Act. However, the proposed rule expands the scope to also include health programs or activities “administered by” recipients of Federal financial assistance from HHS (§92.1). The definition of “recipient” further expands the scope to include individuals who “operate” a health program or activity (confusingly, the proposed rule does not define “administer” nor “operate”), and to indirect recipients of FFA. Moreover, the preamble states that the term “health program or activity” would apply to “all of the operations of an entity principally engaged in providing or administering health services or health insurance coverage” (emphasis added).

To avoid confusion and inadvertent noncompliance, and to align enforcement with the term of the statute, ADA urges OCR to enforce §1557 only with respect to health programs and
activities that are directly receiving FFA for any part of the health program or activity itself, and to exclude:

- Individuals, including individuals who administer or operate health programs or activities.
- Health programs and activities that are receiving indirect FFA or FFA unrelated to the health program or activity.
- Entities that administer or operate health programs or activities or that are receiving indirect FFA or FFA that is unrelated to the health program or activity.
- Entities that administer or operate health programs or activities and that are receiving FFA related to the health program or activity, unless the entity is principally engaged in providing health programs or activities.
- Non-healthcare operations of an entity that is receiving FFA and that is principally engaged in providing or administering health services or health insurance.

**Individuals.** ADA urges OCR not to enforce §1557 against individuals, but only against health programs and activities. Individuals who “administer” or “operate” a health program or activity should only be required to comply if the health program or activity itself receives direct FFA for the health program or activity itself, regardless whether the individual himself or herself receives FFA. Individuals may not know whether or not they “administer” or “operate” a health program or activity, whether the health program or activity receives indirect FFA, or whether the health program or activity receives FFA for a reason unrelated to the health program or activity itself.

If the individual is a doctor, the confusion is only increased by the statement in the preamble that the proposed rule likely covers almost all licensed physicians for several reasons, including the fact that they practice in several different settings. A doctor may not know whether he or she is practicing in a setting that receives FFA, particularly if the FFA is indirect or unrelated to the health program or activity. Moreover, it is unclear whether the proposed rule contemplates exposing doctors to liability in every setting simply because the doctor happens to practice in one setting that receives FFA. Worse yet, such a confusing rule may discourage doctors from practicing in settings that may receive direct or indirect FFA.

Moreover, since the preamble states that FFA will include funds paid to an educational entity on behalf of a student, as well as funds paid to a student and then remitted to an educational entity, the proposed rule discriminates against young doctors of lesser means, who are unable to independently finance their educations or who have not yet finished repaying their student loans. Eliminating individuals from the scope of enforcement would prevent such discrimination.

**Entities.** ADA urges OCR to exclude entities that administer or operate health programs or activities, and that receive FFA unrelated to the health program or activity, as well as entities that administer or operate health programs or activities that receive FFA related to the health program or activity unless the entity is principally engaged in providing or
administering health programs or activities. Without such changes, non-healthcare entities may be discouraged from occasionally providing health services such as health fairs, health screening programs, and charity health events.

**Guidance.** Moreover, for the sake of simplicity and predictability, ADA urges OCR to establish clear guidance as to the scope of enforcement; the preamble to the proposed rule contains ambiguous explanations that will leave many unsure whether they have compliance obligations and potential legal risk under §1557.

**Research.** ADA further urges OCR to exclude research from the scope of §1557 enforcement. As OCR notes in the preamble, “Federal civil rights laws already prohibit discrimination on the basis of race, color, national origin, disability or age in all health research programs and activities that receive Federal financial assistance and prohibit discrimination on the basis of sex in all health research programs conducted by colleges and universities.” Adding an additional layer of compliance requirements and liability risks would burden research with no corresponding benefit to individuals in these protected categories.

3. **Individuals with disabilities**

**Public accommodations.** Public accommodations, including doctors’ offices, are already prohibited from discrimination on the basis of disability. The ADA urges OCR to exempt from enforcement the disability discrimination provisions of §1557 of all health programs and activities that are “public accommodations” under the Americans with Disabilities Act. An additional layer of regulations would only add confusion and compliance burdens, particularly on small practices.

**Accessible Technology.** Health programs and activities that are public accommodations under the Americans with Disabilities Act are already confused about website accessibility because the government is enforcing the Americans with Disabilities Act in this context but has not established standards. The proposed rule would exacerbate this confusion by adding another layer of compliance burden and liability risk and expanding accessibility requirements beyond websites to include other forms of technology such as kiosks, all without the establishment of standards. ADA urges OCR to exempt public accommodations from any accessibility requirements pertaining to websites, to avoid overlap with the Americans with Disabilities Act. ADA further urges OCR to delay enforcement pertaining to technology until health programs and activities can easily select appropriate accessible technology that has been certified by OCR to comply with established standards for accessible technology. The burden of implementing accessibility features should fall on technology companies with expertise in this area, and not on health programs and activities that lack skills and knowledge to select accessible technology – particularly in the absence of standards or certification.
ADA also urges OCR not to impose the requirements of Title II of the Americans with Disabilities Act on health programs and activities that are not covered by Title II. To do otherwise would impose confusing, duplicative and burdensome layers of compliance obligations on health programs and activities. For example, Titles II and III may have different standards for technology accessibility; health programs and activities should be required to comply with one set of standards, not two. Doing otherwise would impose a foreseeable administrative and financial burden, particularly to smaller health programs and activities and those that qualify as small businesses.

**Phased-in approach.** ADA urges OCR to take a phased-in approach to accessibility to reduce the regulatory burden.

**Interpreters.** Public accommodations are already required to communicate effectively with people who have communication disabilities and to provide auxiliary aids and services when needed. However, it is unfair to impose the cost of interpreters unevenly on health programs and activities when the cost could be spread out more fairly through reimbursement. ADA urges OCR to require that all government payors and private payors receiving FFA be required to cover the cost of interpreters as necessary to communicate effectively with people who have communication disabilities.

**Choice of aid or service.** Public accommodations are already required to comply with the Title III requirements of the Americans with Disabilities Act, including the requirements that pertain to the provision of aids and services for individuals with disabilities. OCR proposes to apply the Title II standards to health programs and activities covered by §1557, including the obligation under Title II to give primary consideration to the choice of an aid or service requested by the individual with a disability. ADA urges OCR not to impose any additional or different requirements on covered health programs and activities that are public accommodations under Title III of the Americans with Disabilities Act. To do otherwise would be confusing, duplicative and burdensome, particularly for smaller health programs and activities and those that qualify as small businesses.

**Facilities.** ADA urges OCR not to impose on health programs and activities that are public accommodations under the Americans with Disabilities Act any additional burdens with regard to facility accessibility. For example, if a health program or activity would not, under the Americans with Disabilities Act, be required to be in compliance with a given standard under the 2010 ADA Standards for Accessible Design, then the health program or activity should also be exempt from that standard for purposes of §1557 enforcement.

**Fundamental alteration.** ADA urges OCR to specify that §1557 enforcement will not require a health program or activity to make a “fundamental alteration” in the nature of a health program or activity’s goods or services, undermine the safe operation of the health program or activity, or cause a “direct threat” to the health or safety of others. For example, if, due to an individual’s disability, a health program or activity cannot safely treat the individual, or cannot treat the individual without altering its fundamental nature, the health program or activity does not violate §1557 if it does not treat that individual.

4. **The definition of FFA should not include “services of federal personnel”**
The proposed definition of “Federal financial assistance” includes, among other things, “... any other arrangement by which the Federal government provides or otherwise makes available assistance in the form of . . . services of Federal personnel. . .” The Federal government employed over 2.7 million employees in 2013, according to the U.S. Census bureau.² It would be unfair for any service rendered by any Federal employee to health program or activity to automatically trigger compliance obligations under §1557, and yet the proposed rule does not indicate where to draw the line. It is particularly worrisome that health programs and activities might hesitate to contact Federal outreach programs for compliance assistance out of concern that doing so could expose them to compliance obligations and potential legal risk.

5. Remedial action

Under the proposed rule, if a health program or activity has discriminated, OCR may require the recipient to take remedial action to overcome the effects of the discrimination. This remedial action may be with respect to (1) individuals who are no longer participants in the health program or activity, or (2) individuals who would have been participants in the health program or activity had the discrimination not occurred.

ADA urges OCR to limit the application of remedial action to individuals who either (1) applied to participate but were unable to participate due to alleged discrimination, or (2) who had been participants but are no longer participants due to alleged discrimination. Failure to adopt such limits could unfairly expose recipients to spurious and potentially devastating claims by individuals who would not have been participants notwithstanding any alleged discrimination.

6. Translators for individuals with LEP

More than 200 different languages are spoken in the United States.³ Under the proposed rule, a small health program or activity could unfairly face legal risk for failure to make “reasonable efforts” to provide an “accurate” translation for an individual with limited English proficiency (“LEP”) that protects the individual’s privacy. It is not clear what would constitute a “reasonable effort” to obtain translation services for an individual with LEP, or how a health program or activity is expected to determine that a translation is “accurate.” ADA urges OCR to require government and private payors to select, retain, and reimburse any translator required by a health program or activity that is required to comply with §1557.

**Individual with LEP.** The proposed rule would define “individual with LEP” too broadly, and would impose potential liability on health programs and activities with respect to individuals who do not need translators. The proposed definition would include individuals whose primary language for communication is not English and who have “a limited ability to read, write, speak or understand English.” The phrase “a limited ability” does not indicate the degree of limitation. ADA urges OCR to clarify that “limited ability” is contextual: if an individual whose primary language is not English is able to effectively communicate in the context of the encounter without a translator, then the individual does not qualify as an “individual with LEP” for purposes of §1557. In addition, an individual who is able to speak English but who has a limited ability to read or write English should not be considered an individual with LEP unless the encounter requires the individual to read or write. Moreover, ADA urges OCR to clarify that a translator is not required in all circumstances; for example, when effective communication can be achieved by means of multilingual health history forms and similar resources.

**Taglines and notices.** The proposed rule would require health programs and activities receiving FFA to notify the public of language assistance services, among other things, as well as “taglines” to indicate to individuals with LEP that free language assistance is available. In the preamble, OCR lists 15 languages⁴ to be used in the “taglines.” The list itself is ambiguous: it is unclear whether the languages in parentheses are alternatives or additional requirements (Spanish Creole and Portuguese Creole appear to be alternatives, and French Patois and Cajun appear to be additional requirements). OCR states in the preamble that it considered a State-based methodology for identifying the languages in which covered entities would be required to post taglines. If taglines are to be required, ADA urges OCR to use the State-based method, rather than requiring health programs and activities to indicate that translation services are available in languages for which the health program or activity is unlikely to be able to find a qualified translator.

It is unclear how a health program or activity is expected to make good on its promise in the notice and taglines to provide translation, particularly in those 15 languages if, in spite of reasonable efforts, the health program or activity is unable to secure a qualified translator. ADA urges OCR not to require health programs and activities to post information that overstates their compliance obligations. Requiring health programs and activities to post information that indicates that services are available that a health program or activity may not be able to, or be required to, provide, could expose health programs and activities to liability under federal and state laws on deceptive trade practices. If notice and/or taglines are to be required, ADA urges OCR to include in the required content of both documents a conspicuous statement that the health program or activity is only required to make reasonable efforts to secure qualified translation services when required in the context of the encounter, that translation services may not be required for all encounters and may not be available, depending on the availability of qualified translators.

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⁴ “Spanish (or Spanish Creole), Chinese, Vietnamese, Korean, Tagalog, Russian, Arabic, French Creole, French (including Patois and Cajun), Portuguese (or Portuguese Creole), Polish, Japanese, Italian, German, and Persian (Farsi)” (page 54179)
The proposed rule would require notices and taglines to be published in “significant publications or significant communications” targeted to beneficiaries, enrollees, applicants or members of the public, such as patient handbooks, outreach publications, or written notices pertaining to rights or benefits or requiring a response from an individual, as well as in conspicuous physical locations and on the home page of the website. ADA is concerned that this requirement may imply that the publications, communications and website themselves are available in any language, which is not required and which could generate confusion and misunderstanding as well as burdensome expenses if health programs and activities are expected to translate information that is not essential to the health care encounter. ADA urges OCR to require that any notice or taglines be posted in the physical location, and a brief statement on the website homepage that translation services may be available upon request.

**HIPAA.** A health program or activity should never be required to choose whether to violate HIPAA or §1557. If a health program or activity deems it appropriate to provide a translator, and a translator is available but either refuses to sign a business associate agreement or otherwise violates HIPAA, the health program or activity should be shielded from HIPAA penalties.

**Require reimbursement for translators.** ADA urges OCR to require all government payors, and all private payors who are receiving FFA, to cover any necessary translators for individuals with limited English proficiency, rather than requiring providers to pay for the services of interpreters and translators. Fairness dictates spreading the cost through reimbursement.

**Retain four-factor test.** Small practices must have flexibility in achieving compliance with requirements for access by individuals with LEP because of their limited resources and patient populations. In addition to limiting requirements to “reasonable steps” (92.201(a)) and the evaluation of compliance elements in 92.201(b), ADA urges OCR to also apply the current four-factor test for determining compliance:

1. The number or proportion of LEP persons eligible to be served or likely to be encountered by the program, activity or service provided by the recipient;
2. The frequency with which LEP individuals come in contact with the recipient’s program, activity or service;
3. The nature and importance of the recipient’s program, activity, or service; and
4. The resources available to the recipient and costs.

ADA also urges OCR to apply the “reasonable steps” requirements to all of the health program or activity’s obligations with respect to individuals with LEP, such as the requirement that the translator be a “qualified interpreter.”

Moreover, ADA urges OCR to deem a health program or activity in compliance if a health program or activity (1) determines, based on the service to be provided, that a translator is
not necessary and that adequate communication can be achieved without translation; (2) makes a reasonable attempt to locate a capable translator, even if no translator can be provided; (3) locates and engages a translator who appears capable based on proffered credentials but who provides an inaccurate translation, has a conflict of interest, or fails to comply with interpreter ethics; (4) elects, in an emergency or otherwise, to proceed without a translator or to engage a translator who may not be capable of providing an adequate translation, if the health program or activity believes that to do so is the lesser evil under the circumstances; or (5) fails to provide a translator because no capable translator is willing to sign a HIPAA business associate agreement, or the health program or activity has good faith concerns that the translator will not protect the individual’s privacy.

ADA believes that OCR should not require all health programs and activities to have the capacity to provide interpreters through telephonic oral interpretation services in at least 150 non-English languages. Such a requirement would be overly prescriptive, unnecessary in many geographic areas of the United States, and overly burdensome and costly for smaller health programs and activities and those that qualify as small businesses. For the same reason, ADA urges OCR not to adopt a requirement for health programs and activities to be systematically prepared to provide language assistance services, such as through the establishment of policies and procedures or through other advanced planning mechanisms. The four-factor test (see above) would encourage each health program and activity to plan in advance and develop a program suitable to its environment; no additional advance planning requirement should be imposed, particularly with respect to smaller health programs and activities and those that qualify as small businesses. To do otherwise would impose undue foreseeable burdens on small businesses.

7. Designation of responsible employee and adoption of grievance procedure

OCR proposes requiring applicable health programs and activities that employ 15 or more persons to designate an employee responsible for coordinating compliance with the requirements of §1557 and to adopt grievance procedures and appropriate due process standards. OCR is considering requiring all health programs and activities to do so, and not just those that employ 15 or more persons.

To reduce a foreseeable burden on small businesses, ADA urges OCR to increase the proposed “less than 15 employees” exemption to a “fewer than 50 full-time equivalent employees” exemption, which is a recognized definition of small employer under the Patient Protection and Affordable Care Act.

8. Civil Actions

The statute provides that the enforcement mechanisms provided for and available under title VI, title IX, section 504, or the Age Discrimination Act shall apply for purposes of violations
of this subsection. However, Section 92.302 of the proposed rule provides that “[a]n individual or entity may bring a civil action to challenge a violation of Section 1557 or this part in a United States District Court in which the recipient or State-based Marketplace is found or transacts business.” ADA urges OCR not to provide a private right of action to any individual or entity unless such individual or entity has the corresponding right to a private right of action under the applicable provisions of title VI, title IX, section 504, or the Age Discrimination Act.

For additional information, please contact Dr. Frank A. Kyle, Jr., Manager, Legislative and Regulatory Policy, in the ADA’s Government and Public Affairs Division, telephone 202-789-5175 or kylef@ada.org.

Sincerely,

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