

# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

November 9, 2015

Jocelyn Samuels, Director  
Office of Civil Rights  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 509F HHH Bldg.  
Washington, D.C. 20201

**Re: Comments on Proposed Regulation: Nondiscrimination in Health Programs and Activities  
45 CFR Part 92, RIN 0945-AA02**

Dear Director Samuels,

Justice in Aging appreciates the opportunity to provide comments in response to the proposed regulations implementing Section 1557 of the Affordable Care Act (ACA).

Justice in Aging, formerly the National Senior Citizens Law Center, uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicaid and Medicare, with a focus on long-term services and supports and the particular needs of those dually eligible for Medicare and Medicaid coverage. Ensuring that programs and services are delivered without discrimination based on race, ethnicity, language ability, disability, gender identity, sexual orientation, or other potential disadvantage is at the heart of our work.

We appreciate the dedication of the Department of Health and Human Services (HHS) to develop the first-ever comprehensive regulations to clarify discrimination protections in health programs and activities. As HHS notes in the proposed regulations, individuals who experience discrimination in health care often postpone or do not seek needed care, resulting in adverse effects on their health status; further, discrimination in the health care context can exacerbate existing health disparities in underserved communities.

We commend HHS for its commitment to ending discrimination in all federally funded, supported and conducted health programs and activities. We strongly support the proposed regulations' prohibition of discrimination on the basis of race, color, national origin (including immigration status and language), sex (including sex stereotyping and gender identity), disability, and age.

While the proposed regulations go a long way to implement the promise of Section 1557, there are some glaring gaps. We are surprised and disappointed that HHS did not include Medicare Part B providers as covered entities, as appears to be required by the statutory language in the ACA. We identified several areas that require greater inclusion and specificity to ensure health equity can be achieved.

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We urge HHS to make several improvements to the proposal in the final regulations. As described further below – our key recommendations are as follows:

- I) Include Medicare Part B providers as covered entities.
- II) Set bright line population thresholds to trigger requirements to translate vital documents and post notices.
- III) Ensure the prohibition of sex discrimination is sufficiently broad to encompass all sexual orientation and gender identity discrimination.
- IV) Specify the prohibition of age-related distinctions in health care benefit coverage.
- V) Harmonize disability protections to reflect existing civil rights laws.
- VI) Strengthen enforcement and compliance by setting clear and specific standards.

**I) Include Medicare Part B Providers as Covered Entities**

- 1) Recommend rescinding Part B Exclusions (45 CFR § 92.4)

We oppose the proposed exclusion of Part B providers from coverage within the definition of “Federal financial assistance.” See Nondiscrimination in Health Programs and Activities, Notice of Proposed Rulemaking, 80 Fed. Reg. 54172, 54174 and 54195 (Sept. 8, 2015) (hereinafter “NPRM”). The relationship of Part B providers to HHS cannot rationally be distinguished from that of other providers who are treated as recipients of Federal financial assistance. Further, excluding Part B providers, who are the backbone of the health delivery system, unreasonably limits the scope of Section 1557 and is inconsistent with the plain language and the purpose of the statute.

The agency asserts this exclusion is “consistent with OCR’s enforcement of other civil rights authorities,” NPRM at 54174, and also asserts that the exclusion will impact a relatively small number of physician-providers because most receive federal financial assistance from other sources. *Id.* At 54195. A review of prior HHS documents discussing the agency’s rationale for this exclusion shows that the agency’s historical enforcement posture was based on two justifications: that providers’ relationship with HHS fit into the “contract of insurance” exclusion found in Title VI and Title IX, and that Part B “is basically a program of payments to direct beneficiaries.” See e.g., discussion at 45 C.F.R., Appendix A to Part 84.

Section 1557 explicitly includes contracts of insurance within the definition of federal financial assistance. This statutory language demonstrates that Congress intended to bring contractual insurance payments such as Medicare Part B payments within the scope of Section 1557. Thus, that basis for exclusion of Part B providers vanishes and any arguments about whether the relationship between Part B providers and HHS are based on a contract of insurance are no longer relevant. What remains is HHS’s assertion that Part B “is basically a program of payments to direct beneficiaries.” The agency does not support that assertion with further justification as to why Part B payments are so essentially different in character compared to other provider payments so that they excuse Part B providers from the civil rights obligations imposed on all others receiving HHS funds.

In fact, there is no such difference. A comparison of the agency’s dealings with Part A providers, who have always been considered to be recipients of federal financial assistance, with Part B providers demonstrates that the exclusion is unjustified. Part A and Part B providers both must enroll in

Medicare. Medicare Administrative Contractors (MACs) process both Part A and Part B claims. Both Part A and Part B providers have the right to themselves appeal Medicare coverage determinations—neither must rely on the beneficiary to initiate an appeal.<sup>1</sup> See 42 C.F.R. Sec 405.900 et seq. CMS has itself created a single provider bulletin for Part A & B providers about their appeal rights. See Medicare Learning Network, Medicare Parts A & B Appeals, ICN 006562 (Feb. 2015).

Further, the indicators of the direct relationship between Part B providers, including physicians, and the Centers for Medicare and Medicaid Services are numerous. Part B providers must enroll in Medicare and, as part of that enrollment, certify that they will abide by all Medicare laws, regulations and program instructions applying to them. See Medicare Enrollment Application, Physicians and Non-Physician Practitioners, CMS-8551. They must comply with all applicable conditions of participation in Medicare. *Id.* CMS imposes many direct obligations on enrolled providers. For example, they are limited in the amounts that they charge Medicare beneficiaries; they must provide Advanced Beneficiary Notices when appropriate; they are subject to balance billing prohibitions when serving Qualified Medicare Beneficiaries (QMBs).

The notion that these enrolled providers, subject to multiple conditions for payment and multiple detailed requirements imposed by statute, regulation and sub-regulatory guidance, are merely getting payments passed on by beneficiaries is a fiction, at least as Medicare operates today. It would be particularly inappropriate—and sad—to incorporate this fiction in these regulations. The Part B exclusion has a murky past and, even when first adopted, was inconsistent with the powerful role that Medicare played in desegregating and bringing civil rights into the health care system. See, e.g., David Barton Smith, Racial and Ethnic Health Disparities and the Unfinished Civil Rights Agenda (Health Affairs, Mar. 2005).<sup>2</sup> In a regulation that in so many other ways is groundbreaking, it would be unfortunate indeed to carry over this anachronistic exclusion, the justification of which was strained at the outset and today is without any support.

The proposal to continue the exclusion of Part B providers also severely impinges on the clear intent of Section 1557, which is to extend and strengthen civil rights protections to health care. Part B providers—physicians, home health service providers, durable medical equipment suppliers, etc.—are exactly the providers with whom Medicare beneficiaries interact most frequently. Those interactions are the ones where protections like language access and disability access matter most and have the most direct impact on health outcomes. Excluding the central players in the health care system from coverage under Section 1557 guts the statute.

We recognize that some Part B providers are small entities, including solo practitioners, and that issues of size and resources need to be taken into account when setting enforcement priorities. Those complications can be addressed. They do not justify, however, the wholesale exclusion of the entire category of Part B providers. This is especially true given the rapid consolidation of providers taking place across the entire spectrum of health care.

HHS has asserted that the practical effects of the Part B exclusion will be limited because many Part B providers also receive other forms of Federal financial assistance. NPRM at 54195. We cannot speculate

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<sup>1</sup> It should be noted that even non-participating physicians not billing on an assigned basis can be parties to an appeal. 42 C.F.R. § 405.908 (b)(4).

<sup>2</sup> Available at <http://content.healthaffairs.org/content/24/2/317.full.html>.

on the number of physicians getting other types of Federal financial assistance, though we do note that the HHS analysis was limited to physicians and did not make estimates about other Part B providers. We think the analysis misses the point, however, that there is no justification for the Part B exclusion. Further, as a practical matter, excluding Part B providers from coverage has perverse potential consequences on the broader goals of CMS to transform and improve health care delivery for Medicare beneficiaries. For example, Part B providers could be discouraged from participating in demonstrations or other health delivery transformation efforts because such involvement may subject them to Section 1557 requirements. Medicare-only physicians serving QMBs may be discouraged from seeking Medicaid reimbursement for co-insurance because that would trigger Section 1557 coverage and, instead, decline to accept patients dually eligible for Medicare and Medicaid.

Fundamentally, the Part B exclusion creates confusion and uncertainty. If adopted, Part B providers would need to sort through whether or not they are subject to Section 1557 and OCR would need to evaluate and prove coverage based on every HHS program in which the provider does or does not participate. Bright lines are necessary for providers, for those who regulate them and, most importantly, for beneficiaries who are attempting to access services. We cannot imagine how a Medicare beneficiary denied disability access or language services by a physician could begin to determine whether that particular provider had an obligation to meet the beneficiary's need, despite the fact that the provider was going to be paid by Medicare for the visit.

We strongly urge HHS to reverse its exclusion of Part B providers. All Medicare providers, without exception, should be subject to Section 1557's civil rights mandates. Further, because including Part B providers would constitute a change in existing policy, we ask that HHS explicitly state, within the text of the regulation, that Part B provider payments constitute Federal financial assistance.

Recommendation: Amend § 92.4:

*Federal financial assistance.*

(1) Federal financial assistance means any grant, loan, credit, subsidy, contract (other than a procurement contract but including a contract of insurance), or any other arrangement by which the Federal government provides or otherwise makes available assistance in the form of: (i) Funds; (ii) Services of Federal personnel; or (iii) Real and personal property or any interest in or use of such property, including: (A) Transfers or leases of such property for less than fair market value or for reduced consideration; and (B) Proceeds from a subsequent transfer or lease of such property if the Federal share of its fair market value is not returned to the Federal government.

(2) Federal financial assistance provided or administered by the Department includes all tax credits under Title I of the ACA, as well as payments, subsidies, or other funds extended by the Department to any entity providing health insurance coverage for payment to or on behalf of an individual obtaining health insurance coverage from that entity or extended by the Department directly to such individual for payment to any entity providing health insurance coverage, including contracts for insurance, payments, subsidies, or other funds received directly or indirectly by Medicaid and Medicare providers, including Medicare Part B providers.

## II) **Set Bright Line Population Thresholds to Trigger Requirements to Translate Vital Documents and Post Notices**

### 1) Recommend numerical and percentage thresholds, oppose a multi-factor test (45 CFR § 92.201)

We urge HHS to adopt a combined percentage and numerical threshold for translation of vital documents and to define “vital document” within the regulation.

Although the Department has chosen a multi-factor test for determining what language services should be provided to limited English proficient individuals, it invited comments on alternate approaches including setting thresholds for translation of vital documents. NPRM at 54185. Covered entities need more specific guidance than the multi-factor analysis currently proposed, particularly when determining their obligation to translate documents. While we do not propose scrapping the multi-factor analysis, it should be supplemented with more specific guidance on minimum requirements, particularly with respect to document translation. Without more detailed guidance, asking entities to weigh multiple factors when deciding their obligations for each category of encounter and each document is simply unworkable from both a compliance and an enforcement perspective. Covered entities need clearer standards, LEP individuals need clear understanding of what assistance they can expect, and OCR needs standards that can be easily enforced.

For practical reasons, we propose the regulations:

1. For all encounters and with respect to all documents, require that covered entities must make available, upon request and free-of-charge, qualified interpreter services in all languages. The availability of language line services makes this requirement reasonable. The serious consequences when consumers do not understand their health care services makes it necessary. We note that we support the regulations’ definition of a “qualified interpreter.”
2. Require covered entities to make available written translations of “vital documents” into any “threshold” language. We suggest that the regulations define a “qualified translator” as well as a “qualified interpreter.”
3. Define “vital document,” as including but not limited to one in any of the six categories set out in the Agency’s current LEP Guidance. 68 Fed. Reg. 47311 (Aug. 8, 2003) at 47319.
4. Define “threshold languages” using a “lesser of” combination of percentage and numerical triggers. We recommend using a combined threshold of the smaller of language speakers comprising 5% of the population or 1000 persons in the area served. This threshold is similar to the “safe harbor” standard in current HHS Guidance. 68 Fed. Reg. 47311 (Aug. 8, 2003) at 47319. It differs from the safe harbor in that it uses “area served” rather than “population of persons eligible to be served or likely to be affected or encountered.” We propose using “area served” because it is simpler for both compliance and enforcement and does not require an analysis beyond determining geographical reach.

We propose some flexibility with respect to data sets used. American Community Survey (ACS) data can be the default when no better data set is available but covered entities should be allowed to substitute other data sources that may be more current, more accurate, or more geographically specific, e.g., county data. If states already require use of a different data set, entities regulated by the state should automatically be permitted to substitute the state-mandated data. If not required by a state, a data set

substitution should be submitted to HHS for approval. For entities operating nationally, including most specifically HHS, we propose the same threshold, using ACS data.

Setting translation thresholds is a more workable approach to translation than relying on a multi-factor approach alone. Section 92.201, as proposed, is simply too vague. Unlike the current HHS LEP Guidance, it sets no specific criteria for determining what documents should be subject to a translation requirement and lists no examples of documents that are clearly vital. Instead, the proposed rule sets out a very broad evaluative framework for determining obligations for all types of “communications,” lumping all oral and written communications in one basket. While at a theoretical level, we appreciate that there is a continuum of communications and that an analysis such as proposed might address all nuances, we think that as a practical matter, it simply will not work. Covered entities are either businesses or government agencies. They engage in a myriad range of face-to-face, telephone and website interactions and often issue hundreds of different documents. They are not set up to weigh factors involved in each of these interactions or to engage in an analysis of the nature of the document, the context, etc. And they are not good at it if they try.

Similarly, asking covered entities to weigh the prevalence of a language and, among other things, weigh that against anticipated costs is unreasonable. Small covered entities, especially, are unlikely to do a good job of researching costs or undertaking any systematic and reasonably accurate cost/benefit analysis. Without more direction, they can be expected to have wildly different, though fervently held, views on the burden of particular translations or other language assistance with the result that LEP individuals have significantly different experiences with health care communications.

If Section 1557 is going to live up to its promise of making a genuine difference in language access in health care, its requirements need to be clear, simple and enforceable. Those requirements should include oral language assistance for everyone. They should also include a clear mandate that some documents must be translated, guidelines about what kind of documents are subject to the requirement, and threshold languages that covered entities can easily identify so they know what they must do. Depending on the final regulation, lists of threshold languages could be the result of an analysis of county, state or national data.

*To ensure equity among LEP consumers, thresholds must include a numerical component and not simply be a function of percentages.<sup>3</sup> We have seen in Medicare Part C and D how percentage thresholds alone can severely impact large numbers of LEP individuals in large states and lead to anomalous results. For example, the current CMS marketing regulation for Medicare Advantage plans, 42 C.F.R. Sec. 423.2264(e), requires translation of certain marketing documents if 5% of the population in a plan’s benefit package area speaks a particular language as a primary language. For Chinese translations, this regulation has played out in strange ways. Medicare Advantage plans in a few areas (for example, San Francisco County) must translate materials into Chinese because Chinese speakers meet the 5% threshold in the county. Yet Prescription Drug Plans serving the entire state of California and having far more Chinese speakers in their plan benefit package area are under no translation obligation because Chinese speakers do not comprise 5% of the almost 39 million state residents.*

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<sup>3</sup> One example of a federal regulation using a “lesser of” combination of numerical and percentage thresholds is the Department of Labor’s regulation on foreign languages for pension plans. See 29 C.F.R. § 2520.102-2(c).

*Bright line requirements can help save costs, particularly for translations.* When it is clear what languages will be required for translations and what documents will be covered, it becomes much easier for pooled efforts to lower costs. As has been noted in the discussion in the proposed notice, CMS and other HHS entities can undertake model translations of required documents. Trade associations also can create models and, if requirements are clear, it is very possible and likely that commercial vendors also will step in and take advantage of the opportunity to provide needed documents in multiple languages. In a twenty-first century environment where a limitless number of documents can be stored in the cloud and any office can download and print single copies on demand, a requirement for translation of standard documents is not unduly burdensome.

We recognize that translation of content specific to an individual, e.g., reasons for denial of a particular service, can be costly, particularly for small entities. We therefore propose that non-standard content can be addressed with use of interpreters. We propose that any translated document containing standard language and individualized content must contain a prominent statement in the relevant non-English language advising the recipient to call a toll free number for oral interpretation of non-translated portion of the communication.

*Experience has shown that a test weighing factors without also laying down concrete markers has not worked.* In the two vital programs with which we have the most experience—Medicare and Medicaid—our experience is that when there are clear and specific requirements, state agencies, managed care plans and providers understand their obligations and, for the most part, comply with those requirements. When, instead, the current four-factor test has been left on its own, particularly for translations, virtually nothing has happened.

On the Medicaid side, California is a good example of a state that sets very specific, county based, thresholds and also requirements for the types of documents that must be translated. As a result, the state itself and Medicaid entities routinely translate documents and include multilingual inserts.<sup>4</sup>

On the Medicare side, we have seen reasonable levels of compliance with translation of marketing documents by Part C and Part D plans because CMS has specifically identified the marketing documents required to be translated and has told plans exactly how to identify the languages into which translation is required. But for other non-marketing—but clearly vital—documents such as notices denying coverage or refusing to reimburse payments made for drugs, or disenrolling individuals, where CMS has set no specific requirements, plans have not chosen to provide translations.

*Thresholds are particularly needed to spur agency compliance.* Most concerning is the action of CMS itself, which, pursuant to Executive Order 13166, is expected to have a Language Access Plan that is consistent with the standards in the LEP Guidance but which has interpreted its own obligations narrowly. Although the agency's 2014 Strategic Language Access Plan<sup>5</sup> recites the definition of vital documents found in the LEP Guidance, the fact remains that in the 15 years since Executive Order 13166, the agency—which serves almost 50 million beneficiaries—has not translated any appeals

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<sup>4</sup> For example, see California's Department of Health Care Services All Plan Letter on language translation thresholds, <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/APL2014/APL14-008.pdf>.

<sup>5</sup> Available at <https://www.cms.gov/About-CMS/Agency-Information/OEOCRInfo/Downloads/CMS-LAP-Updated-2014-508.pdf>.

notices into any languages, does not include a multilingual insert in its own mailings to beneficiaries, and has not translated its core annual consumer communication, the Medicare & You Handbook, into any language other than Spanish.<sup>6</sup> Many, many other notices that directly affect entitlement and access remain untranslated. This dismal record suggests that specific mandates, rather than asking covered entities to weigh factors, are the only effective path to compliance and progress in language access.

Recommendation: Amend Section 92.201:

(b) Evaluation of compliance. In evaluating whether a covered entity has met its obligation under paragraph (a) of this section, the Director shall:

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(3) Require, at a minimum, that the covered entity provide oral interpretation, upon request, to any individual with limited English proficiency who requests interpretation in connection with any health program or activity operated by the covered entity;

(4) Require, at a minimum, that the covered entity provide written translations of all standard vital documents for each language that makes up 5% or 1,000 persons, whichever is less, of the population requiring language assistance in the service area and provide with such documents, in-language taglines telling the recipient how to obtain interpreter assistance for non-standard content;

(5) Require that the covered entity demonstrate, upon request, the data source the covered entity used to determine the number of individuals requiring language assistance in the service area.

(i) For the purpose of section (b)(4), vital documents include:

- Consent and complaint forms.
- Intake forms with the potential for important consequences.
- Written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services, actions affecting parental custody or child support, and other hearings.
- Notices advising LEP persons of free language assistance.
- Written tests that do not assess English language competency, but test competency for a particular license, job, or skill for which knowing English is not required.
- Applications to participate in a recipient's program or activity or to receive recipient benefits or services.

(1) Evaluate, and give substantial weight to, the nature and importance of the health program or activity, including the particular communication at issue, to the individual with limited English proficiency; and

(2) Take other relevant factors into account. Such factors may include:

(i) The length and complexity of the communication involved;

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<sup>6</sup> We recognize that CMS has made considerable progress, particularly in the last few years, with respect to oral interpretation at the 1-800-Medicare call center, and has improved language access for its website. Its production of factsheets in several languages also has been helpful. But the gaps in translation of vital documents are large and the speed at which the agency is filling them is frustratingly slow.

- ~~(ii) The context in which the communication is taking place;~~
- ~~(iii) The prevalence of the language in which the individual communicates among those eligible to be served or likely to be encountered by the health program or activity;~~
- ~~(iv) All resources available to the covered entity; and~~
- ~~(v) The cost of language assistance services.~~

2) Translate notices into local threshold languages, not just the top 15 nationally (45 CFR § 92.8)

This lack of access problem is exacerbated when, as in here, the proposed rules do not require the sample notice to be posted in any language other than English. Sec. 92.8(f)(1). Requiring the posting of the English sample notice and the taglines in the top 15 languages is simply inadequate. It is counterintuitive to allow covered entities who knowingly serve specific language groups to be required to only post the sample notice in English, especially when OCR will have already provided translations of the sample notice. The only justification offered in the proposed rules for this minimal requirement is that there may be a burden on physical wall space to post notices in languages frequently encountered by covered entities in their geographic service areas. NPRM at 54179. We remain sensitive to inundating consumers with too much information and diluting the meaning of the message. That said, we recommend requiring covered entities to post the notice in the top three threshold languages for the service area, as well as the requisite taglines posted in the top 15 applicable threshold languages. We believe that this strikes the appropriate balance among ensuring that all LEP beneficiaries know of their rights, respecting a covered entity's physical constraints, and the burden on covered entities.

Recommendation: Amend Section 92.8(f)(1):

Each covered entity shall post ~~the English language~~ notice required by paragraphs (a) and (b) of this section in English and the 3 most prominent non-English languages encountered in the entity's geographic service area as well as and the taglines required by paragraph (d) of this section in a conspicuously visible font size:

3) Ensure notices are available in print to consumers (45 CFR § 92.8)

We recommend that covered entities also be required to provide printed copies of the notice. In our experience with Medicare beneficiaries, physically posting a notice or including information on website has not been as helpful providing the individual with printed information she, or a caregiver, can refer to later when she seeks assistance. For example, the Medicare Part D program requires pharmacies to include a posting about Part D appeal rights. While a helpful first step, this was not enough. Eventually, CMS required pharmacies to hand over a paper notice to the individual when a prescription denied coverage. Based on this experience, we strongly encourage DHHS to require notices posted in conspicuous locations in all threshold languages and also printed and provided to beneficiaries requesting assistance.

Recommendation: Amend § 92.8(f)(1) to add:

- (i) In significant publications and significant communications targeted to beneficiaries, enrollees, applicants, or members of the public;

(ii) In conspicuous physical locations where the entity interacts with the public;  
and

(iii) In a conspicuous location accessible from the home page of the covered entity's Web site;

(iv) on paper in the beneficiary's threshold language to be handed to the beneficiary when the beneficiary requests assistance.

4) Test all notices and taglines with beneficiaries before finalizing (45 CFR § 92.302)

As written, the sample notice language is far too confusing for an individual to realize the notice is informing her of her rights to language assistance or an auxiliary aid. We suggest simplifying the notice to include more direct information. Without clear, well written notices, those with impairments or limited English proficiency will not have the protections and the ability to fully participate in their healthcare. Again, in our experience, dual eligible demonstration states that did not invest in adequate notice testing and preparing for the LEP population found significant challenges with demonstration implementation and rollout.<sup>7</sup> Because the language from the sample notice reads as boilerplate and contains technical jargon, LEP individuals, particularly those with low literacy rates even in their native language, may have difficulty understanding it. As such, we strongly urge DHHS to engage in beneficiary testing of the sample notice language and make changes to the sample notice based on the results of that testing. While we suggest possible changes below, this language or any proposed language for notices should undergo consumer testing.

Recommendation: Amend Appendix A to Part 92:

Appendix A to Part 92—Sample Notice Informing Individuals about Nondiscrimination and Accessibility Requirements:

Discrimination is Against the Law

**We're here to help. Tell us if you need language assistance or assistance with a disability.**

We can provide **free** language interpreters, sign language interpreters, translated written information and information in other formats (large print, audio, accessible electronic formats, and more).

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<sup>7</sup> For example, although California offered notices in all state Medi-Cal threshold languages, much of the additional LEP outreach focused on Spanish speakers given the community's large numbers. In addition, prior to the state engaging in beneficiary testing of the notice materials, many LEP communities reported that the notices were confusing and did not understand their contents. Accordingly, dual eligible beneficiaries from particular language communities, like Korean and Russian speakers, decided not to participate in the project in very high percentages. <http://www.calduals.org/wp-content/uploads/2015/10/Detailed-Opt-Out-102015.pdf> (showing Russian and Korean speakers among the top populations not participating in all counties implementing California's duals demonstration project).

~~[Name of covered entity] complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. [Name of covered entity] does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.~~

~~[Name of covered entity]:~~

- ~~• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - ~~○ Qualified sign language interpreters~~
  - ~~○ written information in other formats (large print, audio, accessible electronic formats, other formats)~~~~
- ~~• Provides free language services to people whose first language is not English when needed to communicate effectively with us, such as:
  - ~~○ Interpreters~~
  - ~~○ information translated into other languages If you need these services, contact \_\_\_\_\_~~~~

### III) **Ensure the Prohibition of Sex Discrimination is Sufficiently Broad to Encompass all Sexual Orientation and Gender Identity Discrimination.**

#### 1) Support prohibiting discrimination on the basis of gender identity (45 CFR § 92.4)

Section 1557 explicitly prohibits discrimination based on sex. To fully address discrimination on the basis of sex, the regulation must include protection against discrimination based on gender identity and sexual orientation. The Section 1557 protection is long overdue and vitally needed to eliminate health disparities among older adults. Multiple studies underscore the discrimination lesbian, gay, bisexual and transgender (LGBT) older adults face from health care and service providers.<sup>8</sup> In a survey of over 4,000 LGBT individuals, 70% of transgender and gender non-conforming adults reported they experienced at least one of the following types of discrimination in health care: being refused needed care, health professionals refusing to touch them or using excessive precautions, health professionals using harsh or abusive language, being blamed for their health status, or health care professionals being physically rough or abusive.<sup>9</sup>

For older adults in long-term care settings, sexual orientation and gender identity discrimination is particularly persistent and harmful. This historic discrimination has prevented many LGBT older adults

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<sup>8</sup> Institute of Medicine of the National Academies (IOM), The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding, [www.ncbi.nlm.nih.gov/books/NBK64806](http://www.ncbi.nlm.nih.gov/books/NBK64806); Lambda Legal, When Health Care Isn't Caring, [www.lambdalegal.org/publications/when-health-care-isnt-caring](http://www.lambdalegal.org/publications/when-health-care-isnt-caring); Karen Fredriksen-Goldsen, et. al., The Aging and Health Report: Disparities and Resilience among Lesbian, Gay, Bisexual and Transgender Older Adults, <http://caringandaging.org/wordpress/wp-content/uploads/2011/05/Full-Report-FINAL-11-16-11.pdf>.

<sup>9</sup> Lambda Legal, When Health Care Isn't Caring, at 5.

from seeking the care they need to stay healthy, resulting in negative health outcomes.<sup>10</sup> A national survey of LGBT older adults in long-term care settings revealed the following:<sup>11</sup>

- Only 22% of respondents felt they could be open with long-term care staff about their sexual orientation and/or gender identity;
- 89% of respondents feared long-term care staff would discriminate against an LGBT elder who was out of the closet;
- Over half (53%) of respondents feared staff would abuse or neglect an LGBT resident.

Additional studies on the mistreatment of LGBT individuals affirms the concern that poor health care treatment is much more common in low income LGBT individuals and people of color.<sup>12</sup>

Accordingly, we support the inclusion of gender identity in the definition of discrimination “on the basis of sex” in the definition section of Section 92.4. We echo the comments of numerous advocacy organizations in suggesting an amendment to the gender identity definition to ensure it protects people of all gender identities, including non-transgender and transgender men and women as well as people of non-binary genders:

Recommendation: Amend § 92.4:

*Gender identity.* The term “gender identity” means an individual’s internal sense of gender, which may be male, female, neither, both, or a combination of male and female, and which may be different from an individual’s sex assigned at birth. The way an individual expresses gender identity is frequently called “gender expression,” and may or may not conform to social stereotypes associated with a particular gender. Gender may be expressed through, for example, dress, grooming, mannerisms, speech patterns, and social interactions. For purposes of this part, an individual has a transgender identity when the individual’s gender identity is different from the sex assigned to that person at birth; an individual with a transgender identity is referred to in this part as a transgender individual.

The approach taken in this definition is consistent with the approach taken by the Federal government in similar matters.

2) Strongly urge HHS to include sexual orientation in “on the basis of sex” definition (45 CFR §92.4)

We are very concerned about the exclusion of sexual orientation in the proposed definition. The absence of explicit protections from discrimination on the basis of sexual orientation in regulation not only ignores the health crisis facing lesbian, gay, and bisexual (LGB) people, but also fails to reflect and reinforce important steps that HHS has already taken under the ACA to explicitly protect LGB people from discrimination on the basis of their sexual orientation. Moreover, the exclusion of sexual orientation from the definition of sex in the proposed rule is out of step with current legal doctrine

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<sup>10</sup> U.S. Department of Health and Human Services, Office of Minority Health, *Improving Data Collection for the LGBT Community*, <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=57>.

<sup>11</sup> LGBT Older Adults in Long-Term Care Facilities: Stories from the Field, <http://www.justiceinaging.org.customers.tigertech.net/wp-content/uploads/2015/06/Stories-from-the-Field.pdf>.

<sup>12</sup> Grant, J.M., et al. (2011). *Injustice at every turn: A report of the national transgender discrimination survey*.

concerning sexual orientation discrimination that has been adopted by other federal agencies and federal courts.

HHS has already used its regulatory authority under the ACA to take steps to address these issues by clarifying that the ACA prohibits insurance carrier practices that discriminate on the basis of sexual orientation.<sup>13</sup> To ensure that the protections of Section 1557 reinforce and harmonize with existing nondiscrimination protections under the ACA—and to protect LGB people not only in gaining access to health insurance coverage but also in successfully accessing health care—the final rule should include explicit protection from discrimination on the basis of sexual orientation.

Federal courts and the EEOC have determined that discrimination based on sexual orientation is a form of sex discrimination prohibited by Title VII. In *Baldwin v. Foxx*, the EEOC ruled in favor of a Department of Transportation employee who alleged that he did not receive a promotion because of his sexual orientation.<sup>14</sup> The EEOC found that Title VII prohibits employers from relying on “sex-based considerations” when making personnel decisions and that these protections apply equally to LGB individuals under Title VII. The EEOC further clarified that “[a] complainant alleging that an agency took his or her sexual orientation into account in an employment action necessarily alleges that the agency took his or her sex into account.”<sup>15</sup>

Failure to incorporate this consistent legal trajectory into the final rule would concretize a harmful and outdated interpretation of the law and would put HHS policy out of step with both federal courts and other federal agencies, including the Office of Personnel Management, the EEOC, the Office of Special Counsel, and the Merit Systems Protection Board.<sup>16</sup>

Without an explicit prohibition on discrimination on the basis of sexual orientation, LGB older adults will continue to face discrimination, isolation and fear as health care covered entities will not be required to adhere to a regulatory discrimination prohibition.

Recommendation: Amend § 92.4:

- *On the basis of sex* includes, but is not limited to, on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, or gender identity, or sexual orientation.

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<sup>13</sup> Kellan E. Baker, *Open Doors for All: Sexual Orientation and Gender Identity Protections in Health Care* (Apr. 2015), available at: <https://www.americanprogress.org/issues/lgbt/report/2015/04/30/112169/open-doors-for-all>.

<sup>14</sup> EEOC Appeal No. 0120133080, 2015 WL 4397641, at \*5 (July 16, 2015). The Commission has developed this interpretation in a long series of decisions prior to *Baldwin*. See, e.g., Complainant v. Johnson, EEOC Appeal No. 0120110576 (Aug. 20, 2014); Complainant v. Cordray, EEOC Appeal No. 0120141108 (Dec. 18, 2014); Complainant v. Donahoe, EEOC Appeal No. 0120132452 (Nov. 18, 2014); Complainant v. Secretary, Dept. of Veterans Affairs, EEOC Appeal No. 0120110145 (Oct. 23, 2014); Couch v. Dep’t of Energy, EEOC Appeal No. 0120131136 (Aug. 13, 2013); Brooker v. U.S. Postal Service, EEOC Appeal No. 0120112085 (May 20, 2013); Culp v. Dep’t of Homeland Security, EEOC Appeal No. 0720130012 (May 7, 2013); Castello v. U.S. Postal Service, Appeal No. 0120111795 (Dec. 20, 2011); Veretto v. U.S. Postal Service, EEOC Appeal No. 0120110873 (July 1, 2011).

<sup>15</sup> *Id.*

<sup>16</sup> Office of Personnel Management, *Addressing Sexual Orientation and Gender Identity Discrimination in Federal Civilian Employment* (2015).

- Add language defining sexual orientation to § 92.4 as follows:<sup>17</sup>  
*Sexual orientation means homosexuality, heterosexuality, or bisexuality.*
- 3) Strongly oppose any limitation to the regulation’s protections on the basis of religious refusal (45 CFR § 92.2)

We strongly oppose any additional exemption that would permit discrimination based on religious views. There is no religious concern that warrants permitting health care entities who use federal funds to discriminate against other individuals.

Nothing in the text of Section 1557 authorizes the addition of a religious exemption—and adding such exemptions could cause great harm to members of the vulnerable populations that Section 1557 is intended to protect, including LGBT people.

We are concerned that adding an exemption to the Section 1557 regulations would allow hospitals, long-term care and other providers to use religious beliefs as a shield for discriminatory actions targeting LGBT people. For example, a religious exemption would open the door for religiously affiliated covered entities to refuse to provide transition-related health care services for transgender individuals or refuse to assist LGBT individuals with activities of daily living (ADLs) in a long-term care setting.<sup>18</sup> An exemption could also contravene the intent of Section 1557 and other federal nondiscrimination laws by allowing hospitals and other covered entities to deny transition-related health care coverage or same-sex spousal coverage to their employees.

In order to reflect the ACA’s clear intent and its overriding purpose of ensuring that no one should face discrimination in health care on any protected basis, including sex, the Section 1557 regulations should not contain a religious exemption.

- 4) Support equal access to health programs without discrimination on the basis of sex (45 CFR § 92.206)

We support the proposed requirement that covered entities provide equal access to health programs or activities without discrimination on the basis of sex and must also treat individuals consistent with their gender identity. Discrimination in access to gender-specific facilities remains one of the most common forms of discrimination against transgender individuals by arbitrarily singling them out for categorical denials of coverage for procedures and services that are the same or substantially similar to those provided to non-transgender individuals.

Recommendation: Maintain § 92.207(b)(3) without any changes and amend the proposed provisions at §§ 92.207(b)(4)-(5):

(4) Categorically or automatically exclude from coverage, or limit coverage for, all health services related to gender transition, including gender reassignment surgeries and other services or

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<sup>17</sup> This definition is adapted from the Equality Act (H.R. 3185, 114th Cong. § 1101, 2015).

<sup>18</sup> For examples and stories of long-term care facilities refusing to assist LGBT individuals with activities of daily living, see *LGBT Older Adults in Long-Term Care Facilities: Stories from the Field* at 15, <http://www.justiceinaging.org.customers.tigertech.net/wp-content/uploads/2015/06/Stories-from-the-Field.pdf>.

procedures described in the most current version of the recognized professional standard of medical care for transgender individuals; or

(5) Otherwise deny or limit coverage, or deny a claim, for specific health services related to gender transition if such denial or limitation results in discrimination against a transgender individual. A denial or limitation results in discrimination if, inter alia, (a) an individual is denied coverage for services to treat gender dysphoria even though substantially similar services are covered for treatment of other conditions, (b) a medically necessary service for treating gender dysphoria is denied solely because that service is designated as categorically cosmetic when used to treat other conditions, (c) an individual is denied access to medically necessary health services that are in accordance with the most current version of the recognized professional standard of medical care for transgender individuals.

- Amend § 92.207(d) as follows:

Nothing in this section is intended to determine, or restrict a covered entity from determining, whether a particular service is medically necessary or otherwise meets applicable coverage requirements in any individual case, provided that the determination of medical necessity or meeting applicable coverage requirements is not itself discriminatory and does not result in discrimination.

- 5) Support the inclusion of explicit prohibition against discrimination on basis of association (45 CFR § 92.209)

We support the inclusion of the explicit prohibition against discrimination on the basis of association. This language is critical for protecting members of many vulnerable groups from discrimination, such as people with disabilities and lesbian, gay, or bisexual individuals.

#### **IV) Specify the Prohibition of Age-Related Distinctions in Health Care Benefit Coverage**

Section 1557's application to age related discrimination should prohibit age related distinctions in benefit coverage. We recommended specifying in Section 92.2(b)(1) that these distinctions are prohibited, apart from exclusions in the Age Act for (1) age distinctions contained in a federal, state, or local statute or ordinance that provides benefits based on age, establishes criteria for participation in age-related terms, or describes intended beneficiaries to target groups in age-related terms, and (2) actions that reasonably take into account age as a factor necessary to the normal operation or the achievement of any statutory objective of such program or activity.<sup>19</sup> Thus, for example, a decision to limit coverage of a service to individuals in a particular age range, even though that service is also effective for individuals of other ages, would violate Section 1557 if the age limitation is not based on a statute or ordinance and is not necessary for the normal operation or achievement of the goals of the service.

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<sup>19</sup> MPRM at 54173; 42 U.S.C. §§ 6103(b)(1)(A), (b)(2).

## **V) Harmonize Disability Protections to Reflect Existing Civil Rights Laws**

People with disabilities are likely to fall into more than one protected group as disability affects people of all races, ethnicities, genders, languages, sexual orientations, gender identities, and age. A growing number of older adults are aging with a disability. In 2008-2012, 38.7% of older adults, aged 65 and older, reporting having one or more disabilities.<sup>20</sup> For older women, the numbers are higher. 50.9% of older women report having a disability.<sup>21</sup> The proposed Section 1557 regulations make important improvements to address the needs of older adults with a disability. We echo the comments of numerous advocacy organizations urging the agency to carefully incorporate existing Section 504 and Americans with Disabilities Act (ADA) regulations in a manner that does not narrow the ambit of Section 1557. We share their recommendation to harmonize regulatory standards and concepts within Section 504's cited regulations. We urge that the final regulations protect the concept of provider choice for health consumers with disabilities, and support their recommended regulator language for harmonizing disability nondiscrimination protections. Please see the Subpart B, Nondiscrimination Provisions comments from the Consortium for Citizens with Disabilities for their analysis.

## **VI) Strengthen Enforcement and Compliance by Setting Clear and Specific Standards**

A strong enforcement mechanism for Section 1557 is an essential element of this proposed regulation, and we appreciate HHS's ongoing commitment to enforcing Section 1557 through both administrative and judicial avenues. Without adequate enforcement, the protections against discrimination based on race, color, national origin, sex, age or disability cannot be realized.

- 1) Support the proposed clarification that Section 1557 permits a private right of action (45 CFR § 92.302)

We strongly support the private right of action created by Section 1557(a), which demonstrates a legislative commitment to ensuring that individuals who have been harmed by discrimination in the health care context can seek redress of their injuries in federal court. In our experience, many individuals, especially low-income Medicare and Medicaid beneficiaries, who are more likely to be limited English proficient, women, people of color, and people with disabilities, require this avenue to ensure their rights are fully protected.

Without this private right, individuals who believe they have suffered from discrimination under 1557 would have no judicial recourse and would be limited to seeking agency enforcement to address discrimination. Unfortunately, OCR lacks the capacity to always respond to complaints in a timely fashion or to provide redress to all persons who have suffered discrimination. HHS's own report indicates that although significant steps have been taken to reduce the backlog of OCR complaints, a concentration of older cases as well as recent increases in cases received have made it difficult for OCR

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<sup>20</sup> U.S. Census Bureau, Older Americans with Disabilities: 2008-2012, <https://www.census.gov/content/dam/Census/library/publications/2014/acs/acs-29.pdf>.

<sup>21</sup> *Id.*

to investigate all complaints in a timely manner.<sup>22</sup> A private right of action secures a straightforward and efficient path to vindicate a protected class member's rights.

2) Recommend clarifying substantive legal standard and include disparate impact (45 CFR §92.302)

To ensure greater protection for victims of discrimination, more specific guidance is necessary with respect to private enforcement. We urge that HHS clarify the applicable substantive legal standard to employ when adjudicating such claims in the regulation. Section 92.302 of the proposed regulation explicitly provides that an individual or entity can file suit in federal district court when a violation of Section 1557 has occurred. The statute incorporates existing civil rights laws to indicate the grounds upon which discrimination is prohibited, however, these laws carry different legal standards and burdens of proof.

For example, both Title VI, which prohibits discrimination on the basis of race, color, or national origin, and Section 504 of the Rehabilitation Act, which prohibits discrimination on the basis of disability, are incorporated into Section 1557. However, disparate impact claims have been foreclosed in the Title VI context, while they are not under Section 504. *See Alexander v. Sandoval*, 532 U.S. 275, 293 (2001) (holding no private right of action exists under Title VI for disparate impact claims); *Alexander v. Choate*, 469 U.S. 287, 299 (1985) (indicating that Section 504 reaches conduct that has a disparate impact on people with disabilities). There is a lack of clarity regarding the appropriate standard for Section 1557. Without guidance, courts have already begun reaching inconsistent decisions regarding the appropriate standard to apply. *Compare Rumble v. Fairview Health Services*, 2015 WL 1197415, \*11-12 (D. Minn. Mar. 16, 2015) (holding that one standard and burden of proof applies to cases under Section 1557) with *Southeastern Pennsylvania Transportation Authority v. Gilead Sciences, Inc.*, 2015 WL 1963588, \*6, (E.D. Penn. May 4, 2015) (holding that the protected class determines the appropriate legal standard and burden under Section 1557).<sup>23</sup> This variation demonstrates the critical need for this proposed regulation to clarify the substantive legal standard courts should use when adjudicating a discrimination claim under Section 1557.

In deciding what the standard should be, we find language from *Rumble* persuasive: "Here, looking at Section 1557 and the Affordable Care Act as a whole, it appears that Congress intended to create a new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff's protected class status. Reading Section 1557 otherwise would lead to an illogical result, as different enforcement mechanisms and standards would apply to a Section 1557 plaintiff depending on whether the plaintiff's claim is based on her race, sex, age, or disability." *Id.* at 11. In other words, as the *Rumble* court explains, it would not make any sense for a Section 1557 plaintiff claiming race discrimination to be barred from bringing a claim using a disparate impact theory but then allow a Section 1557 plaintiff alleging disability discrimination to do so.

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<sup>22</sup> <http://www.hhs.gov/ocr/office/about/cj2013.pdf>, pg. 15.

<sup>23</sup> Note that of the handful of cases brought under Section 1557, only *Rumble* and *Gilead* discuss the question of standards and burdens of proof. The other cases do not reach this question. *See Callum v. CVS Health Corp.*, 2015 WL 5782077, \*18 (D.S.C. Sept. 29, 2015); *Cruz v. Zucker*, 2015 WL 4548162, \*12 (S.D.N.Y. July 29, 2015); *East, et. al. v. Blue Cross and Blue Shield of Louisiana*, 2014 WL 8332136, n.1 (M.D. La. Feb. 24, 2014).

In keeping with Congress' intent that Section 1557 would bring a new level of commitment to nondiscrimination in healthcare, we recommend consistent, protective mechanisms for addressing discrimination for individuals protected by these crucial civil rights statutes. A single standard will best protect beneficiaries with a claim to redress practices that have a discriminatory, disparate impact as well as practices of intentional discrimination. It is essential that Section 1557 regulations recognize both discriminatory intent and disparate impact claims, as discrimination may be subtle and is often hidden in the very structure of our society. Section 1557 regulations should protect against disparate impact discrimination in the strongest possible terms.

Recommendation: Amend § 92.301-303:

*§ 92.301 Enforcement mechanisms.*

~~The~~ Any and all enforcement mechanisms available for and provided under Title VI, Title IX, Section 504, ~~or~~ and the Age Act shall apply for purposes of Section 1557 and this part with respect to covered entities.

*§ 92.302 Procedures for health programs and activities conducted by recipients and State-based Marketplaces.*

(c) An individual or entity may bring a civil action to challenge a violation of Section 1557 or this part, under any cognizable theory of discrimination, including disparate impact, in a United States District Court in which the recipient or State-based Marketplace is found or transacts business.

*§ 92.303 Procedures for health programs and activities administered by the Department.*

The following subsection should be added:

(e) An individual or entity may bring a civil action to challenge a violation of Section 1557 or this part, under any cognizable theory of discrimination, including disparate impact, in the United States District Court for the District of Columbia, or in a United States District Court in which the Federally-facilitated Marketplace or other Department-administered program or activity is found or transacts business.

3) Recommend vigorous ongoing monitoring and enforcement (45 CFR § 92.302)

Finally, the current regulations do not include any detail regarding ongoing monitoring for enforcement. HHS cannot rely exclusively on individual complaints and must employ a proactive enforcement approach, including secret shopper surveys, to test whether appropriate assistance is available. Individuals living in poverty, who are in frail health, and/or limited English proficient are reluctant to complain, and many will not understand their rights under the regulations. We discovered that in our extensive campaign to end balance billing – when Medicare providers bill low income seniors and other dual eligibles for Medicare cost-sharing – many beneficiaries did not know about this basic consumer protection, and those who were aware often did not want to jeopardize longstanding relationships with

trusted healthcare providers and instead silently paid the bills. Older adults and vulnerable populations are not well situated to bear the burden of identifying violations.

We are pleased that the proposed regulations allow OCR to access critical sources of information to investigate and ensure whether health programs and activities are compliant with Section 1557's mandate and that Section 92.303 explicitly prohibits retaliation. We expect HHS will employ the entire arsenal of enforcement approaches to ensure genuine progress in enforcement of the rights protected by Section 1557.

We support the Affordable Care Act's aim of expanding access to health care and health coverage for all individuals, and appreciate this proposed regulation's recognition that equal access for all individuals without discrimination is essential to achieving this goal. To this end, we recommend that the proposed regulations apply to all federally funded, supported and conducted activities and not just those of HHS.

Thank you for the opportunity to comment on these proposed rules. We commend HHS for issuing these vitally important proposed regulations and urge that this rulemaking be finalized as soon as possible. If you have any questions or need further information, please contact Jennifer Goldberg, Directing Attorney at [JGoldberg@JusticeInAging.org](mailto:JGoldberg@JusticeInAging.org), (202) 683-1996.

Sincerely,

A handwritten signature in black ink, appearing to read "K. Prindiville". The signature is written in a cursive, slightly slanted style.

Kevin Prindiville  
Executive Director  
Justice in Aging