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October 3, 2022

Secretary Xavier Becerra
U.S. Department of Health and Human Services (HHS)
Office for Civil Rights (OCR)
Attention: 1557 NPRM (RIN 0945-AA17)
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

RE: RIN 0945-AA17; Nondiscrimination in Health Programs and Activities; published in 87 (149) Federal Register 47824-47920 on August 3, 2022.

Submitted electronically via https://www.regulations.gov

Dear Secretary Becerra,

UnityPoint Health appreciates this opportunity to provide comments in response to the Notice of Proposed Rulemaking on Section 1557 of the Affordable Care Act ("1557 NPRM"). UnityPoint Health is one of the nation's most integrated health care systems. Through more than 32,000 employees and our relationships with more than 480 physician clinics, 40 hospitals in urban and rural communities, and 14 home health agencies throughout our 9 regions, UnityPoint Health provides care throughout Iowa, central Illinois, and southern Wisconsin. On an annual basis, UnityPoint Health hospitals, clinics, and home health agencies provide a full range of coordinated care to patients and families through more than 8.4 million patient visits.

UnityPoint Health appreciates the efforts of the Department of Health and Human Services (HHS) to ensure the accessibility of health care services for these individuals, and as a general matter, supports the language of the 1557 NPRM. As a member of the American Hospital Association, we support their formal comment letter and reiterate that "Hospitals and health systems value every individual we have the privilege of serving, regardless of race, religion, national origin, sexual orientation or gender identity." UnityPoint Health's comments offer a health system perspective and are particularly focused on accessibility to health care services by individuals with limited English proficiency or with disabilities. We thank you for your consideration of the following input.

ACCESSIBILITY TO HEALTH CARE SERVICES BY INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY OR WITH DISABILITIES

PART 92—NONDISCRIMINATION IN HEALTH PROGRAMS OR ACTIVITIES—Subpart A (General Provisions)

1. *Definitions (§ 92.4)*

   a. *Qualified interpreter for an individual with a disability.*

   Comment: **UnityPoint Health recommends that the definition of "Qualified interpreter for an individual with a disability" include the requirement that such individual*, for purposes of providing interpretation services*, be certified or assessed by a formal process that objectively measures the competency of the individual.** Doing so would help covered entities meet the regulatory definition (i.e., ascertaining "qualified") and would potentially ease the burden on the covered entity in making the determination. We are especially concerned that interpreters have the requisite knowledge of medical terminology. As a larger health system, we treat complex disease and need to rely on interpreters who can correctly communicate information to patients.

   We recognize that several organizations could offer such certification or assessment, including covered entities, local or national organizations, as well as vendors who provide interpretation services. We also recognize that some states require American Sign Language (ASL) interpreters to be licensed, in which case separate certification may not be required. **We would appreciate any assistance that OCR could provide by offering optional assessment tools and other resources, perhaps through a webpage with resources or toolkit.**

   b. *Qualified interpreter for a limited English proficient individual.*

   Comment: **UnityPoint Health recommends that the definition of a "Qualified interpreter for a limited English proficient individual" include the requirement that such individuals, *for purposes of providing interpretation services*,[1] be certified or assessed by a formal process that objectively measures the competency of the individual.** As stated above, we are concerned that interpreters be able to correctly communicate medical terminology.

   c. *Qualified translator.*

   Comment: For the same reasons set forth in "1.a" and "1.b" above, **UnityPoint Health recommends that the definition of a "Qualified translator" include the requirement that such individuals, for purposes of providing interpretation services, be certified or assessed by a formal process that objectively measures the competency of the individual.**

   d. *Additional definitions*.

   Comment: UnityPoint Health suggests adding a definition of "minor" which references applicable state law—the approach used by the HIPAA Privacy Rule.

2. *Designation and responsibilities of a Section 1557 Coordinator (§ 92.7)*

   Comment: **UnityPoint Health supports the designation of a Section 1557 coordinator**. Compliance with Section 1557 and other nondiscrimination requirements requires a level of expertise which should be centralized in an accountable employee and their designees to ensure that their covered entity is compliant.

[1] We recognize that some clinicians who see patients speak the same native language. Our comments do not address this situation and should not require these providers to obtain a certification. Rather, the focus should be on employees who, in addition to their regular job duties, are asked to provide interpretation services.

That being said, as a health system comprised of multiple entities, we would appreciate clarification that appointment of a single 1557 coordinator for the parent of a system, with designees appointed for each affiliated subsidiary organization, would be acceptable. In addition, while we support the designation for all covered entities, we would appreciate clarification and examples on how this could be met for covered entities of various sizes without being too prescriptive. In particular, it is unclear whether the obligation could be met by utilizing outside counsel or other contracted third parties, parent company employees, and/or covered entity staff whether designated in policy or formally responsible in a job description. Overall, **we urge OCR to adopt a flexible approach for designation of a single 1557 coordinator that allows the covered entity to determine what is best for it based on its complexity and size and needs of the community it serves without restricting options**.

As noted in our comments under *§* 92.9 below, we appreciate OCR's provision of sample training material, sample documents/forms, sample policies, and other materials needed to ease the burden on covered entities.

3. *Policies and procedures (§ 92.8)*

a. *§ 92.8(a)--General requirement.*

Comment: UnityPoint Health appreciates the flexible approach provided by this section. However, we seek further guidance on what is meant by the following language: "…taking into account the size, complexity, and the type of health programs or activities." Specifically, a health system that has hospitals, clinics, home care entities, and home medical equipment retail settings may meet the 1557 Rule requirements in different ways depending upon the setting. We have noted specific examples of this in the below discussion.

b. *§ 92.8(c)—Grievance procedures.*

Comment: **UnityPoint Health requests clarification of what is meant by an "equitable solution."** While we all strive for that, what is "equitable" is subjective and is in "the eye of the beholder." We believe that it would be better to require a resolution that ensures that the grieving individuals are afforded access as required under the 1557 NPRM.

c. *§ 92.8(d)—Language access procedures.*

Comment: UnityPoint Health proposes that "qualified bilingual staff members", for purposes of providing interpretation services, be subject to the same standards as a "qualified interpreter for a limited English proficient individual" and "qualified interpreter for an individual with a disability", including the requirement to be certified or assessed as described in our comments regarding "definitions" above. Use of staff to interpret can create quality of care issues, as the staff member may be taken from their other job responsibilities to interpret. Contingency plans should be in effect if that occurs. Further, if staff members are used, their interpretation responsibilities should be formally recognized as part of their job duties. Policies and procedures should be adopted to address these issues.

4. *Training (§ 92.9)*

Comment: UnityPoint Health is grateful for the technical assistance materials already made available by CMS. We urge the development of additional materials including training decks, sample documents/forms, sample policies, and other materials needed to ease the burden on covered

entities. Open door forums are also helpful.

UnityPoint Health also understands that OCR limited the training requirements to "relevant" individuals in order to support efficient and practical training. While we certainly appreciate this approach, **we urge consideration that *all* staff be trained in a health care covered entity, with such training tailored to their job duties**. Within a health care system, it is possible that all employees may encounter a patient—whether on a daily basis as part of their job or simply meeting a patient in the hallway or cafeteria. All staff should understand the basic concepts of Section 1557 and receive training relevant to their positions within a covered entity. For some, training on specific Section 1557 processes will be necessary.

5. *Notice of nondiscrimination (§ 92.10)*

a. *§ 92.10(a)(1)(ii)—Reasonable modifications.*

Comment: We recommend that *§* 92.10(a)(1)(ii) reference "braille, large print, *or qualified reader*." Even for larger health systems such as UnityPoint Health, braille may not be economically feasible.

b. *§ 92.10(a)(2)—Requirements for providing notice.*

Comment: Thank you for your request for input on whether the notice of nondiscrimination requirement as proposed is practical, likely to be effective, and responsive to concerns raised regarding the 2016 and 2020 Rules, including the sufficiency of the content of the notice and requirements regarding when and where covered entities must provide the notice. We have several comments.

First, from an inpatient and home care perspective, the requirement to provide this notification information may be duplicative. Through Medicare Conditions of Participation and/or through accrediting bodies as part of patient rights, this notification occurs upon admission into service through admission paperwork. Requiring an annual notification is unnecessary and potentially confusing, especially when the individual may not be an ongoing recipient of services.

In clinic settings, in particular, annual distribution, as required under *§* 92.10(a)(2), is administratively burdensome and, given the extensive publication of language assistance through other means required under the 1557 NPRM, should not be necessary—unless the notice changes. Instead, **we recommend an approach similar to that provided under the HIPAA Privacy Rule wherein the notice (i.e., Notice of Privacy Practices) is provided at the first point of service and upon request thereafter**. In a health system with many "points of contact" for a patient, an integrated health record facilitates asking the patient once about their language assistance needs, eliminating the administrative burden of multiple queries at multiple points of contact as the patient moves through the continuum of care. A more effective approach to ensuring access would be to confirm at each time of service, with respect to individuals who have previously declined language assistance from the covered entity, if they now wish for language assistance services provided by the covered entity.

Overall, we believe that the covered entity should have flexibility to determine which type of notification--annual, upon admission to health care services/programs, at first point of service, or targeted to a particular population on a regular basis-- works best for the covered entity.

6. *Notice of availability of language assistance services and auxiliary aids and services (§ 92.11)*

a. *§ 92.11(b)—Language requirements.*

Comment: UnityPoint Health supports effective communication of the availability of language assistance services; however, we respectfully ask that OCR reconsider its reference to the top 15 languages *of the state*. Because there may be significant differences across a state in the languages required for interpretation, **we ask that covered entities be afforded the ability to choose to either provide notice in the top 15 language of the state or the top languages in the respective service area for the covered entity.** Taking this approach would also be consistent with the language used in § 92.201(a) (i.e., "…provide meaningful access to each limited English proficient individual eligible to be served or likely to be directly affected…").

b. *§ 92.11(c)—Requirements for providing notice.*

Comment: For similar reasons provided in our comments regarding § 92.10(a)(2), **we urge reconsideration of the requirement to annually distribute the notice**.

In addition, the requirement to provide this notification with each item in the list of documents may be redundant in many covered entities. For example, a health care provider may have several of the documents specifically listed all in one admission packet or may have separate touch points where various documents are provided. It would seem redundant for those with multiple "touch points" to have to provide the same information for the same episode of care at each touch point. In addition, it would seem redundant for the covered entity to have to provide notification upon admission, discharge, with complaint forms, and with the billing invoices, versus having the Notice apply to all dealings with the covered entity in relation to the services provided.

We believe that the covered entity should be responsible to determine when, where, and how often the Notice is provided, and the list of specific documents should be options for a covered entity to consider.

Finally, we note the following with respect to distribution of the notice: **Given the prevalence of human trafficking or domestic/child abuse, we suggest that it may be beneficial, where appropriate, to ascertain directly with the patient and not in the presence of an accompanying adult whether or not a patient wishes to use the accompanying adult to provide interpretation services.** Doing so will need to assessed on a case-by-case basis and be done with discretion so as to not result in greater harm to the patient or in a potentially violent situation.

PART 92—NONDISCRIMINATION IN HEALTH PROGRAMS OR ACTIVITIES—Subpart C (Specific Applications to Health Programs and Activities)

1. *Meaningful access for limited English proficient individuals (§ 92.201)*

a. § 92.201(a)—General requirement.

Comment: **UnityPoint Health is concerned about the 1557 NPRM's requirement that a "covered entity must take *reasonable* steps to provide meaningful access to each limited English proficient individual eligible to be served or likely to be directly affected by its health programs and activities."** While we appreciate the commentary in the Federal Register regarding what might be considered "reasonable", further guidance on what to do in certain situations would be helpful. In this regard, we note that there are a number of scenarios where UnityPoint Health affiliates have been unable to provide a qualified translator—despite best efforts to do so. In some instances, securing a rare dialect

can be very difficult. In addition, in some settings—particularly home care—there may be limited connectivity to secure an on-line interpreter. Even if we use a phone translator, the length of time "on-hold" may prevent the provision of treatment in a timely manner, and patients may have difficulty hearing phone translation. These may not be emergent situations, and the request to use a family member may not be *initiated by the patient* (see comments on *§* 92.201(e)(2)(ii) below). Hence, they are not covered under the exceptions set forth in *§* 92.201(e)(2). Nevertheless, we believe that our attempting to secure an individual to provide interpretation services who may not be "qualified" (e.g., a member in the community) to be reasonable under those circumstances. **We would support a requirement to document efforts used to secure a qualified interpreter.**

b. § 92.201(c)(3)—Specific requirements for interpreter and translation services.
Comment: With respect to *§* 92.201(c)(3), **we request additional guidance on the use of machine learning.** We seek clarity from OCR related to what situations are "critical to the rights, benefits, or meaningful access of a limited English proficient individual" and what situations might not qualify as such.

c. § 92.201(e)(2)(ii)—Restricted use of certain persons to interpret or facilitate communication.
Comment: **UnityPoint Health asks that the Section 1557 Rule address nonemergent situations where the patient does not "specifically request" that an accompanying adult interpret or facilitate communication, but where, despite best efforts to find an interpreter, it is not possible to find a qualified interpreter for a limited English proficiency individual**. These often occur when a patient speaks a rare dialect of a language (e.g., Marshallese). In those cases, a provider may need to initiate a discussion with the patient to find out where they are from (e.g., using a map) and then proceed to locate a community member who speaks the rare dialect.

We also encourage OCR to consider an exception for situations where family members or friends--including a minor—accompany a patient in the retail setting of a home medical equipment company. The limited English proficient individual may be purchasing a cash item that is "not critical to the rights, benefits, or meaningful access of a limited English proficient individual", including, for example, compression socks, canes, reachers, lift chairs, commodes, etc. This is akin to the patient going to a drug store or the medication area of a grocery store.

d. *§ 92.201(e)(4)—Restricted use of certain persons to interpret or facilitate communication*.
Comment: As stated above, we are concerned about the reliance on "qualified bilingual/multilingual staff to communicate directly with limited English proficient individuals." Under the current definition of "qualified bilingual/multilingual staff", there is no mechanism provided to ensure that the individual is "qualified" *when providing interpretation services.* As stated above, we support a formal process that objectively reviews the interpreter's proficiency. We also support development of processes to govern use of staff to ensure quality of care. The need for interpretation for one patient should not interfere with the care of other patients for whom the staff member is responsible. For example, if Clinician "A" is attending to their own patients but is asked to provide interpretation for patients of Clinician "B", then Clinician "A" may not be able to complete all scheduled visits.

UnityPoint Health suggests that Section 1557 Rule include a provision allowing a covered entity to

use a qualified interpreter even in situations where the patient has requested that a family member or friend provide language assistance services. As illustrations, if a provider believes that the family member or friend may not be accurately communicating with the patient or appear to be struggling when interpreting; if a health provider suspects in good faith that an individual may be a victim of trafficking or abuse (discussed above); or if a provider is concerned that an alternative method of communication may result in misunderstandings (e.g., lip reading for the Deaf or Hard of Hearing), then the health provider should be able to utilize a qualified interpreter.

We are pleased to provide input on the 1557 NPRM and its impact on our health care system, our patients, and communities served. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Executive Director, Government & External Affairs at (319) 361-2336 or cathy.simmons@unitypoint.org.

Sincerely,

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Compliance Director

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