August 13, 2019

Roger Severino, Director
Office for Civil Rights
Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, D.C. 20201

RE: Nondiscrimination in Health and Health Education Programs or Activities Proposed Rule

Dear Director Severino:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the June 14, 2019 proposed rule amending regulations under Section 1557 of the Affordable Care Act (ACA).

MGMA is the premier association for professionals who lead medical practices. Since 1926, through data, people, insights, and advocacy, MGMA empowers medical group practices to innovate and create meaningful change in healthcare. With a membership of more than 45,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 practices of all sizes, types, structures, and specialties that deliver almost half of the healthcare in the United States.

On May 18, 2016, the Office for Civil Rights (OCR) under the Department of Health and Human Services (HHS) finalized regulations implementing Section 1557 at 45 C.F.R. Part 92 (2016 regulations) and on June 14, 2019 proposed to amend certain provisions of those regulations. While some of the most significant proposals in the June 14, 2019 rule relate to discrimination on the basis of sex, certain provisions of OCR's proposals impact the implementation and enforcement of Section 1557's prohibition of discrimination on the basis of disability and nationality.

MGMA recognizes that patients come from a broad spectrum of cultures and beliefs. We strongly support physicians and medical group practice leaders conducting themselves with appropriate respect for patients' social and cultural beliefs and furnishing care without regard to race, religion, gender, sexual orientation, gender identity, ethnic affiliation, health, age, disability, or economic status. We are concerned, however, that aspects of existing Section 1557 regulations result in unintended consequences and costs for our members. We wish to comment on certain provisions of Section 1557's regulations and proposed revisions pertaining to access standards for individuals with limited English proficiency (LEP) and communications-based disabilities. We offer the following suggestions to OCR:

- **Establish federal reimbursement opportunities or funding for practices administering language assistance services to LEP individuals.** The cost to provide language assistance services is not inconsequential, and physician group practices are reporting financial losses when treating patients that require interpretation or translation services. Providing reimbursement at the federal level would help offset the extra costs incurred to provide these services free of charge and appropriately reimburse group practices for the increased upfront expenses and physician and clinical staff time required to care for LEP patients.

- **Mitigate conflicts with longstanding federal non-discrimination rules.** There are a multitude of legal requirements at the federal and state level that address discrimination against individuals with LEP and communications-based disabilities. OCR should harmonize requirements where there is logical synergy, especially in areas where 2016 Section 1557 regulations modified standards leading to additional and confusing requirements in areas that had longstanding, existing rules in place.
- **Title III of the Americans with Disabilities Act (ADA) should be the standard that applies to private businesses covered by Section 1557 regarding effective communication for individuals with disabilities.** In the 2016 regulations, OCR codified at 45 CFR 92.202 that Title II effective communication standards will apply to Section 1557 covered entities, a provision ordinarily reserved for state and local governments, rather than Title III, which generally applies to private businesses. There are important differences between Title II and Title III standards, which Congress contemplated when crafting different titles under the ADA. MGMA recommends that OCR modify its regulations to apply Title III standards, as was the case prior to the 2016 regulations.
- **Finalize the proposal to eliminate the requirement to post notices and taglines in at least 15 languages.** Based on feedback from our membership, we agree with OCR that these notices have not yielded the intended benefits for individuals with LEP.

Effective communication for LEP individuals

Establish a reimbursement mechanism

We commend OCR for emphasizing the importance of clinician-patient communication and for acknowledging that the level, type, and manner of language assistance services should vary based on the capacity of the covered entity. Efforts to prevent discrimination and facilitate effective communication should be flexible and allow for consideration of the resources available to covered entities in order to avoid the unintended consequences of costly administrative burdens, which could jeopardize patient access altogether.

The cost to implement translation and interpretation services and programs can be significant, particularly for small group practices and entities that treat high volumes of LEP individuals. Section 1557 covered entities are prohibited from charging the patient or the patient's health plan for auxiliary aids or services, even if the costs for such aids exceed the payment made for the clinician's services or the patient/individual requiring an aid fails to show up for an appointment. When using a face-to-face interpretation service, costs may range from $50-$150 per hour and may include a minimum hour requirement and/or transportation fee. For example, one MGMA member from an endocrinology practice in rural Oregon reported the practice was billed nearly $300 for one single in-person interpreter service this June. The interpreter was present for 48 minutes but charged a two-hour minimum rate at $100 an hour, plus a transportation fee of $89. The practice was reimbursed just under $185 for services furnished to the individual needing interpretation services, meaning the practice lost around $100 on the visit. The practice reported paying $1,200 in interpretation fees for the month of June alone for nine individuals requiring language assistance services, including one $110 charge for a patient who never showed up. These fees are unsustainable and are jeopardizing access to care for vulnerable patient populations.

For LEP patients that are uninsured or underinsured, losses incurred as a result of expensive translation or interpretation fees are compounded when a practice does not receive full reimbursement for care. One MGMA member in Virginia described how their practice treats many uninsured patients and offers less than market rates through a discounted fee schedule or waived costs in order to increase access to care for the uninsured population of central Virginia. When these patients require language assistance services, these expenses increase net losses.

MGMA members recognize the importance of providing effective communication to individuals, particularly patients; however, this unfunded mandate is creating financial strain for our nation's physician group practices. We strongly urge HHS to consider potential reimbursement mechanisms to account for these costs and to work with relevant federal agencies on how this can be achieved. MGMA supports direct payments through Medicare to reimburse clinicians for the added expense and time related to providing care for LEP individuals. As the largest payer of healthcare services in the country, the Centers for Medicare & Medicaid Services (CMS) is in a position to influence policies adopted by commercial payers and Medicare Advantage plans and establishing reimbursement at the federal level may set in motion reimbursement opportunities across multiple payers. We understand the necessity of providing auxiliary aids and language assistance services free of charge to individuals in need of these services; however, we believe physician practices should receive separate payment from public and private payers for providing such services. Unfunded mandates cause significant burdens on physician practices and divert resources away from patient care. As the Department of Justice (DOJ) pointed out in its LEP guidance around Title VI of the Civil Rights Act, "reasonable steps may cease to be 'reasonable' where the costs imposed substantially exceed the benefits."[1]

Notice standards

The proposed rule would eliminate the requirement that covered entities mail and/or otherwise distribute notices of non-discrimination and "taglines" regarding the availability of language assistance services free of charge in at least 15 languages. MGMA supports OCR's proposal to eliminate this requirement.

The requirement to display taglines in the physical office, on a practice's website, and in significant communications[2] has generated significant confusion for group practices and individuals they encounter, and based on feedback from MGMA members, has resulted in little benefit to their patient populations.

Practices are required to list their own phone number on the taglines, meaning when an individual presents in the physical office and calls the phone number listed on the tagline, the practice's own telephone rings. Many practices use automated messaging to better direct patient calls; therefore, when an individual calls the practice's number, they reach a messaging system in English. Alternatively, if a staff member from the physician group practice answers the phone, the staff member and individual on the phone may not be able to communicate with one another to determine what services are required and in what language. Even if the number of a translation or interpretation service were included on these taglines rather than the practice's own phone number, MGMA members report that language assistance vendors require that group practices, as the payer and solicitor of language assistance services, initiate the language assistance services by identifying the language needing to be interpreted or translated. Most importantly, our members informed us that patients and individuals do not look at these taglines notices despite being prominently displayed.

Effective communication for individuals with disabilities

OCR proposes to retain and re-designate provisions related to accessibility for individuals with disabilities[3] but seeks comment on whether to change certain provisions intended to ensure equal access for people with disabilities, including whether there is confusion or added complexity arising from any lack of consistency. OCR also seeks comment on whether the agency should consider certain exceptions

[1] DOJ Clarifying Memorandum Regarding LEP and Executive Order 13166 (Oct. 26, 2001).
[2] 45 CFR 92.8.
[3] 45 CFR 92.202 – 92.205.

to accessibility provisions, such as an exception to effective communication standards for covered entities with fewer than 15 employees.

Section 1557's implementing regulations incorporate and modify requirements under the ADA and Section 504 of the Rehabilitation Act of 1973 (Section 504) regarding effective communication with individuals with disabilities. In particular, OCR requires all Section 1557 covered entities to comply with Title II of the ADA's effective communications standards, which are ordinarily reserved for state and local governments, even if the covered entity is a private business or place of public accommodation. The effect of this modified standard is that Section 1557 covered entities must now give "primary consideration" to the choice of auxiliary aid requested by an individual with a disability. In contrast, prior to the issuance of the 2016 regulations, Title III entities such as physician group practices were encouraged to consult with the person with a disability to discuss what aid is appropriate.

While supporting the central goal of the ADA to communicate effectively with individuals with communication-based disabilities, we do not agree with OCR's decision to apply Title II standards to all Section 1557 entities. The primary consideration standard is not appropriate for use in a clinical setting. The treating clinician or entity is in the best position to determine the kind of services necessary to address the needs of their patients.

We agree that the type of auxiliary aid provided by a group practice should depend on specific circumstances, however the "primary consideration" standard has evolved such that patients will demand that a particular translator or interpreter be used, regardless of the expense. For example, one medical group practice reported a patient came in for an appointment accompanied by a hired interpreter, without disclosing to the practice that the interpreter was for-hire or offering the practice an opportunity to consider alternatives or negotiate contracted expenses. The patient then submitted an interpretation services bill to the practice, which included charges such as a "port-to-port" transportation fees and a service minimum of two hours. Practices may contract with language assistance entities to negotiate fair rates and drive down practice expenses, however when patients demand use of a certain company or specific commercial service, this creates additional unnecessary costs, when the translation vendor offered by the practice may provide perfectly sufficient language assistance services.

Furthermore, applying Title II standards to private businesses is counter to legislative intent. When promulgating ADA regulations, the DOJ offered the following interpretation: "the Department believes that Congress did not intend under title III to impose upon a public accommodation the requirement that it give primary consideration to the request of the individual with a disability."[4] Rather, "the Department finds that strongly encouraging consultation with persons with disabilities, in lieu of mandating primary consideration of their expressed choice, is consistent with congressional intent."[5]

Lastly, applying Title II standards to private entities has created significant confusion for medical group practices accustomed to following longstanding Title III rules. Moreover, it is unclear from the 2016 regulations whether Section 1557 covered entities are subject only to the heightened "primary consideration" standard or must follow the entire regulatory scheme of Title II. For example, all ADA entities are required to provide auxiliary aids or services unless doing so would result in an "undue burden," defined as a significant difficulty or expense. Determining what constitutes an undue burden is factual, and the DOJ has set forth separate standards and factors to consider depending on whether an entity is covered by Title II or Title III. "[I]n determining whether a particular aid or service would result

[4] 75 FR 56236, 56282 (Sept. 15, 2010) (Title III), citing 1991 guidance.
[5] 56 FR 34141, 35567 (July 26, 1991).

in undue financial and administrative burdens, a title II entity should take into consideration the cost of the particular aid or service in light of all resources available to fund the program, service, or activity and the effect on other expenses or operations. The decision that a particular aid or service would result in an undue burden must be made by a high level official, no lower than a Department head, and must include a written statement of the reasons for reaching that conclusion."[6] This standard that is clearly meant to apply to a state/local government does not have practical application in a private business setting, leaving physician group practices with no clear guidance on how to determine whether a particular aid would constitute an undue burden.

We believe that covered entities should be encouraged—not required—to consider the preference of an individual requesting or requiring an auxiliary aid or services. MGMA urges OCR to create harmonization between Section 1557 regulations and the ADA by revising the standard that applies to private entities covered by Section 1557 such that it aligns with the ADA.

Exception for entities with fewer than 15 employees

OCR solicits comments on whether to establish an exception to the requirement to provide effective communication for individuals with disabilities for entities with fewer than 15 employees. Section 504 regulations permit such an exception, but also allow OCR to impose this requirement on entities with fewer than 15 employees if the furnishing of auxiliary aids and services would not significantly impair the ability of the entity to provide the benefits or services. MGMA supports OCR creating an exception exempting entities with fewer than 15 employees from these requirements, as this will help alleviate financial and administrative burden for smaller physician group practices that may already have limited resources.

Conclusion

We appreciate the opportunity to share our comments on this important issue. Should you have any questions, please contact Mollie Gelburd at mgelburd@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg, MGA
Senior Vice President, Government Affairs

[6] "Effective Communication," DOJ, available at: https://www.ada.gov/effective-comm.htm.