

October 3, 2022

Melanie Fontes Rainer
Director
Office of Civil Rights
Department of Health and Human Services

Via electronic submission to www.regulations.gov

**Re: Notice of Proposed Rulemaking: Docket ID: HHS–OS–2022–0012, RIN: 0945–AA17,
Nondiscrimination in Health Programs and Activities**

Dear Director Fontes Rainer:

The Center for Medicare Advocacy (the Center) is a national, non-profit law organization that works to ensure access to Medicare, health equity, and quality healthcare. The organization provides education, legal assistance, research and analysis on behalf of older people and people with disabilities, particularly those with long-term conditions. The Center’s policy positions are based on its experience assisting thousands of individuals and their families with Medicare coverage and appeal issues. Additionally, the Center provides individual legal representation and, when necessary, challenges patterns and practices that inappropriately deny access to Medicare and necessary care. We appreciate the opportunity to submit these comments to the above-referenced rule.

1557 Should Apply Broadly to Health Programs and Activities

We strongly support the proposal to restore regulatory provisions recognizing that Sec. 1557 applies to federal health programs like Medicare and Medicaid, the ACA’s state and federal Marketplaces and the plans sold through them, as well as other commercial health plans if the insurer receives any form of federal financial assistance. This is consistent with the statutory language and the purpose of the ACA to ensure broad access to and coverage of health care.

HHS asks for comment on whether these nondiscrimination protections should be extended to non-health programs and activities of the agency. We strongly encourage the adoption of such protections for these other programs in separate rulemaking and urge HHS to make those protections equally robust as those proposed here for health programs and activities. HHS operates many programs, including some authorized by the Older Americans Act, that are not “health” programs but are nonetheless vital to older adults’ well-being and often contribute directly to social determinants of health. Similarly, we urge HHS to work with the Department of Justice and other agencies that administer health programs to develop a common rule to implement section 1557. We believe establishing unified standards and nondiscrimination

protections across all HHS programs and among health programs of other agencies would provide clarity both for covered entities and program participants as well as promote consistent enforcement.

Medicare Part B Meets the Definition of Federal Financial Assistance

We strongly support HHS's proposal to treat Medicare Part B payments as federal financial assistance (FFA) and Part B providers and suppliers as recipients under 1557, Title VI, Title IX, Section 504, and the Age Act. This change in interpretation is well-supported by the evolution of how the Part B program operates, the fact that most Part B providers are already receiving other forms of FFA, and the clear intent of the Sec. 1557 statute. It will eliminate confusion for older adults and people with disabilities who are not in the position to know whether their Medicare provider receives other FFA. And, most importantly, it will help ensure that people with Medicare have the same protections and rights regardless of the Medicare provider they choose, the Medicare-covered service they are receiving, or whether they are in Original Medicare or Medicare Advantage. Bringing all Medicare providers under this rule will also help increase access to quality health care for those who face the most discrimination and barriers, as many Medicare providers also serve people with other forms of insurance.

Ensuring Meaningful Access to for Individuals with Limited English Proficiency

It is critical that older adults have robust language access resources and protections from discrimination. These provisions are key to ensuring that the more than 6.5 million people over age 60 and four million Medicare beneficiaries with limited English proficiency (LEP) can access care and services, receive important health care information in a language they understand, and are informed of their rights and how to enforce them.¹

Health care information is complex and can only be communicated effectively in an individual's primary language. Most people's health care needs increase and become more complicated as they age. Furthermore, older adults may be less inclined to ask for language assistance, out of a fear of inconveniencing others, even if the language assistance is necessary for them to truly understand their health care. LEP older adults may feel pressure to rely on family members as interpreters, even if those family members are not qualified to interpret health information, which can inhibit the older adult's understanding of their health status and instructions from their provider. Language barriers also exacerbate existing health disparities in communities of color and immigrant communities.

We strongly support the regulatory provisions to restore and clarify the covered entity's duty under Sec. 1557 to take reasonable steps to provide meaningful access to *each* individual with LEP eligible to be served or likely to be directly affected by its health programs or activities. The 2019 rulemaking's watering down of this requirement, along with the elimination of the in-language taglines and notices discussed below, harmed access to quality care for LEP older

¹ The Center is co-counsel *Chinatown Service Center v. HHS*, No. 1:21-cv-331 (JEB), which seeks to restore protections in health care for people with LEP under Section 1557.

adults. These requirements can be the difference between getting needed health care and not even knowing one's health care needs.

We recommend that HHS add a requirement that a "companion" of an LEP individual who needs language services be provided meaningful access including qualified interpreters and translated materials. People who are LEP, including older adults, may be parents/guardians for minors, may have legal decision-making authority, or may be accompanying their spouse or other family member as a caregiver or support person. Their understanding of the information is often as critical as the person receiving health care services. Providing a clear right to language services for companions will also help deter inappropriate reliance on family members and others as interpreters.

To facilitate timely access, we recommend requiring covered entities to note in the record (including electronic health records, client/patient files) for each individual they serve whether language access is required and, if so, what language.

We also recommend that HHS specifically require covered entities to develop a communication access plan that addresses both language access and accessibility for individuals with disabilities, including supporting disabled people who are LEP. It is important for covered entities to plan for what types of language services and communication supports they may need to provide by gathering data about the LEP population in their service area, for example. This information is necessary to develop effective "language access procedures" for how to schedule an interpreter, how to identify whether an individual is LEP, etc. that the proposed rule requires.

Providing Notice of Nondiscrimination and Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

We strongly support the requirements related to providing notice of nondiscrimination. Notifying individuals of their rights is fundamental to successful implementation of any civil rights law, including Sec. 1557. After the 2019 rulemaking eliminated this provision, individuals receiving health care and long-term services and supports (LTSS) were no longer made aware of their rights under 1557. This has been especially harmful to LEP older adults who do not know that they have a right to an interpreter or how to access other language access services, and to people with disabilities who may not have the information they need to access necessary auxiliary aids and services. In addition, without this notice, people who experience discrimination may not know that they can file a complaint or a grievance or how to do so.

We strongly support the proposal to require covered entities to provide a notice of availability of language assistance services and auxiliary aids and services and that this notice be translated. We agree with HHS's approach to clarifying the requirements for when this notice must be made available and providing individuals with the opportunity to opt out of receiving these notices. To inform people with vision impairments of their rights and help them access these services, we recommend that HHS require covered entities to also include a large print notice of availability (minimum of 18-point font). With regard to the translated notice, we agree with the proposed approach of using the top 15 languages by state as the minimum standard. However, we recommend clarifying that a covered entity that operates across multiple states must provide the

notice in the top 15 languages in each of those states. We also urge HHS to consider a more localized standard, such as the standard for Medicare Advantage Plans and Prescription Drug Plans which considers the plan service area. Using service area or counties, rather than states, could help ensure smaller language communities that are often concentrated in a particular area of a state are also receiving in-language notices.

To help ensure the notice of availability is as informative as possible, we also suggest that HHS develop and provide covered entities with model notices that are tailored to the different types of communications on which they are included. For example, rather than having the same generic notice on all communications, a notice of availability should indicate that a response is required or that the communication contains information about one's rights or benefits.

Designating a Section 1557 Coordinator, Establishing Policies and Procedures, and Training Employees

We support the proposal to require covered entities to have a designated Section 1557 coordinator. HHS requested comment on whether this provision should apply to entities with fewer than 15 employees, and we recommend that it should. Even in smaller covered entities, it is essential that someone is responsible for coordinating implementation of Section 1557 including developing the required policies and procedures, ensuring relevant employees are trained, receiving and addressing grievances, and informing individuals of their rights when they interact with the covered entity. We believe this is especially important for entities providing long-term services and supports (LTSS) to older adults and people with disabilities. Smaller LTSS providers are common and often preferred by older adults and people with disabilities because the services they provide are often daily and intimate. While preventing discrimination is critical in all health care settings, having a coordinator to ensure that 1557 is implemented is essential to daily life for someone who resides at a covered entity or receives home- and community-based services. The coordinator role will likely vary from entity to entity and we believe the proposed description of the coordinator's duties allows for such variation and minimizes burden on smaller entities. For example, a smaller entity would not have to have the coordinator role be a full-time job.

The Center has been conducting significant advocacy for Medicare beneficiaries with chronic, long-term, and disabling conditions who are trying to make use of the Medicare home health benefit. These beneficiaries face significant barriers to accessing Medicare-covered home health services they qualify for. Some Medicare-certified home health agencies are small, and it is critical that they be as up-to-date on Section 1557 policies and procedures, and as prepared to address beneficiary grievances as larger home health agencies are. This applies to providers of other types of health services as well.

We strongly support the provisions requiring covered entities to adopt Sec. 1557 policies and procedures and to ensure their employees are trained on them. We agree with HHS that both employees in "public contact" positions and those who make decisions about these policies and procedures should receive training so they understand the requirements of Sec. 1557. Again, the Center's experience with assisting beneficiaries trying to access the home health benefit has

emphasized the importance of all staff members of any particular Medicare-certified agency being knowledgeable on antidiscrimination policy and its application.

As discussed above, we recommend that HHS require entities to develop a communication access plan that addresses both the needs in their service area for language access and accessibility for individuals with disabilities.

Prohibiting Discrimination in Automated Decision-Making

We agree with HHS that clinical algorithms can be discriminatory and particularly harmful to Black patients, as they often dictate that Black patients must be more ill than white patients before they can receive treatment for life-threatening conditions such as kidney disease and heart failure. We support the proposed provision to prohibit discrimination through the use of clinical algorithms in decision-making. However, we request that HHS broaden the prohibition to include any form of automated decision-making system. For older adults and others, there are numerous examples of discrimination in decision-making tools and systems that may fall outside the term “clinical algorithm,” including assessment tools for skilled nursing facilities and home and community-based services for both level of care determinations and services allocation that discriminate against groups or deny services needed to attain and maintain community integration; Medicaid eligibility systems that wrongfully deny or terminate coverage; “gender conflicts” in health decisions that lead to misdiagnoses and discrimination in health care settings; utilization review practices that are based on financial motives rather than generally accepted standards of care.

In our clients’ experience, Medicare Advantage plans are more frequently employing artificial intelligence to conduct utilization management at the beginning of care, and during care periods to discontinue coverage, to predetermine length of services based on Medicare prohibited rules-of-thumb, with little to no individualized assessment or ongoing evaluation of the patient’s treatment needs. At a minimum, HHS should define the term “clinical algorithms” because it may otherwise be too narrowly construed. For example, the Crisis Standards of Care, which frequently lead to intersectional discrimination against older adults and disabled people of color, may not be “clinical algorithms” under a narrow definition because they were often policies or ranking systems rather than automated decisions.

Prohibiting Discrimination in Benefit Design

We strongly support the proposed provisions to prohibit discriminatory plan benefit design and marketing practices. Older adults are more likely to have chronic conditions and disabilities, and therefore have higher health care needs. Despite established protections for people with pre-existing conditions, insurers continue to discriminate against people with costlier conditions and greater needs by dissuading them from enrolling or shifting more out-of-pocket costs to people with certain conditions.

For example, prior authorization, which is very common in Medicare Advantage plans, results in obstacles to necessary care. Prior authorization and other utilization management tools can serve as significant barriers to care that both current and prospective Medicare Advantage enrollees are

often unaware of until they need to access services. As noted by the Kaiser Family Foundation in a June 2021 report², virtually all MA enrollees are in plans that require prior authorization:

Medicare Advantage plans can require enrollees to receive prior authorization before a service will be covered, and nearly all Medicare Advantage enrollees (99%) are in plans that require prior authorization for some services in 2021. Prior authorization is most often required for relatively expensive services, such as inpatient hospital stays, Part B drugs, and skilled nursing facility stays, and is rarely required for preventive services. Prior authorization is also required for the majority of enrollees for some extra benefits (in plans that offer these benefits), including comprehensive dental services, hearing and eye exams, and transportation. [...] In contrast to Medicare Advantage plans, traditional Medicare does not generally require prior authorization for services and does not require step therapy for Part B drugs.

Because prior authorization is most frequently utilized for expensive services and not preventive services, this utilization management technique disproportionately affects sicker and older beneficiaries with chronic conditions.

The Department of Health & Human Services, Office of Inspector General (OIG) released reports in 2018 and in 2022 highlighting the concerning use of prior authorization in Medicare Advantage. In 2018, the report titled “Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials,”³ found “widespread and persistent problems related to denials of care and payment in Medicare Advantage’ plans.” The report’s findings included that when beneficiaries and providers appealed preauthorization and payment denials, MA plans “overturned 75 percent of their own denials.” At the same time, “beneficiaries and providers appealed only 1 percent of denials to the first level of appeal.”

The 2022 report focusing on Medicare Advantage plan denials titled “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care,”⁴ found “widespread and persistent problems related to inappropriate denials of services and payment.”

OIG’s findings – in both its 2018 and 2022 reports – are consistent with the Center for Medicare Advocacy’s experiences both assisting and hearing from Medicare Advantage enrollees. All too

² Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico & Tricia Neuman, *Medicare Advantage in 2021: Premiums, Cost Sharing, Out-of-Pocket Limits and Supplemental Benefits*, Kaiser Family Foundation (June 21, 2021).

³ Department of Health and Human Services Office of Inspector General, Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials, OEI-09-16-00410 (Washington, D.C.: September 2018).

⁴ Department of Health and Human Services Office of Inspector General, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, OEI-09-18-00260 (Washington, DC: April 2022).

often, MA plans deny or, even more frequently, prematurely terminate care that would otherwise be covered through traditional Medicare.

Strong Prohibitions on Sex Discrimination are Necessary to Address Health Disparities for LGBTQ+ Older Adults

We strongly support the proposed broad regulatory language to prohibit discrimination on the basis of sex that specifically includes discrimination on the basis of sex stereotypes, sex characteristics, including intersex traits, sexual orientation, and gender identity (Sec. 92.101). LGBTQ+ older adults experience pronounced health disparities and higher poverty rates compared to their heterosexual and cisgender peers due in large part to historical and ongoing discrimination. We support CMS's strong recognition of discrimination that LGBTQ+ nursing home residents experience, and the need to address this discrimination as part of its attention to health disparities.

Prohibiting Discrimination in Telehealth Services

We support the newly proposed provision on telehealth and the recognition of it as a tool to improve access for individuals who, for various reasons, are unable or prefer to receive services in person. As telehealth has expanded during the COVID-19 pandemic, access has not been equitable for LEP individuals and people with disabilities due to the telehealth platforms themselves being inaccessible. Therefore, we recommend that HHS require telehealth platforms to allow a third-party interpreter or use of auxiliary aids and services. Second, all of the communication about telehealth that occurs prior to a telehealth appointment (e.g., scheduling, system requirements, testing connections, appointment reminders, and log-on instructions) must be accessible to people with LEP and people with disabilities.

A study focusing on California found that patients with LEP had half the odds of using telehealth services compared with those who were English proficient.⁵ Even when those with LEP are able to access telehealth, the systems are generally not designed to support them. Systemic challenges with telehealth services, such as accessing information on health portals, mean that LEP individuals are potentially greatly limited in fully utilizing the resources available to those who are English proficient. According to a senior center health educator the Center spoke with in California, one hurdle faced by those with LEP face challenges is reading their lab results on health portals such as MyChart. "Clients find it difficult to interpret their test results because it's all written in English. They can only depend on the graphic (recommended range) to understand whether they are in the 'green/health' range."

Similarly, platforms should be adopted to meet the needs of older adults and people who are autistic, deaf or hard of hearing, blind, deaf/blind, movement impaired, or otherwise have difficulty in communicating via traditional telehealth models.

⁵ Jorge A. Rodriguez et al., *Disparities In Telehealth Use Among California Patients With Limited English Proficiency*, Health Affairs (Mar. 2021).

We also would like to stress the importance of telehealth for Substance Use Disorder Treatment. The Center supports making permanent flexibilities in telehealth developed in response to the COVID pandemic for Substance Use Disorder Treatment. Specifically, as outlined in our comments to CMS on the Physician Fee Schedule, we support making permanent the flexibility to allow OTP intakes to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with buprenorphine, and to permit the use of audio-only communication technology to initiate treatment with buprenorphine in cases where audio-video technology is not available to the beneficiary – including circumstances in which the beneficiary is not capable of or has not consented to the use of audio-video technology. The ability to prescribe buprenorphine via telehealth adopted during the COVID-19 pandemic has lowered or eliminated many previous barriers to care faced by patients in certain settings, and has the potential to lower barriers in more.

By eliminating these barriers, individuals with SUDs can rapidly enter treatment when they express the desire to do so, which is critically important when treatment delays can lead to resumed use, overdose, or death. Especially in communities where there are lower rates of providers who can prescribe buprenorphine, allowing initiation via telehealth will continue to bridge the treatment gap between white and BIPOC Medicare beneficiaries and promote greater access to care in rural and underserved communities. CMS has also documented that beneficiaries who accessed medications for opioid use disorder (MOUD) had lower use of inpatient and/or emergency department visits than beneficiaries who did not access MOUD, which “suggests that more effective management of OUD generally may help reduce use of more acute and costly care.” We also urged CMS in our previous comments to work with the DEA and SAMHSA to make permanent the authority to prescribe buprenorphine via telehealth to ensure consistent access to life-saving SUD medications.

Demographic Data Collection is Critical to Civil Rights Enforcement

The Proposed Rule acknowledges that demographic data collection and civil rights enforcement are inextricably linked. We agree. We recommend that HHS adopt a demographic data collection requirement and establish demographic data collection as a function of civil rights monitoring. Demographic data collection requirements should align with the demographic characteristics enumerated within the rule (race, ethnicity, language, disability, age, sex, sexual orientation, gender identity, pregnancy status, and sex characteristics) and allow for intersectional analysis. HHS should incorporate existing data collection practices and engage in additional research where necessary. While covered entities should be required to request demographic data, individuals’ responses must be voluntary and should be self-reported to ensure accuracy and privacy. HHS must also ensure that data collected is maintained safely and securely by the appropriate entities and implement strict standards to make clear that data cannot be used for negative actions such as immigration or law enforcement, redlining or targeting of specific groups. Additionally, HHS should provide appropriate training and technical assistance resources to programs and grantees, including training on how to explain why data is being collected.

These protections will help to ensure that data collected can be best utilized to prevent discrimination and disparities in health care and access.

I. Conclusion

Thank you for the opportunity to submit these comments. For additional information, please contact Alice Bers, Litigation Director at ABers@medicareadvocacy.org or Kata Kertesz, Senior Policy Attorney at KKertesz@medicareadvocacy.org.

Sincerely

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