COMMUNITY HEALTH CARE ASSOCIATION of New York State

October 3, 2022

Melanie Fontes Rainer
Director
Office for Civil Rights
Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

RE: Nondiscrimination in Health Programs and Activities

Dear Director Fontes Rainer:

The Community Health Care Association of New York State (CHCANYS) writes this letter as New York's primary care association representing more than 70 federally qualified health centers (FQHCs), also referred to as community health centers (CHCs), or simply health centers. New York's health centers serve more than 2.3 million patients annually; 68% are Black, Indigenous, or other people of color and 28% are best served in a language other than English.

Health centers are highly regarded and trusted within their communities because they tailor their health care services and supporting programs to meet the unique needs of their patients. Rooted in the civil rights movement, health centers prioritize providing high quality, affordable and accessible health care to anyone who walked through their doors. Health centers continue to embody equity through their mission statement and applaud the Biden Administration for strengthening Section 1557 and protecting patients' access to respectable care. CHCANYS appreciates the opportunity to provide comments on the proposed rule and has detailed them by section below.

Nondiscrimination Provisions - *Discrimination Prohibited*

Health centers have long been trusted health care settings for the LGBTQ community. Several health centers specialize in serving LGBTQ patients and provide services such as hormone therapy, mental health care needs, resources for unstable housed LGTBQ youth, and HIV treatment and prevention. Health centers are committed to providing patient-centered care and investing in workforce training to ensure staff understand best practices to provide informed and inclusive care.

CHCANYS appreciates OCR's clarification in paragraph (a)(2) of *(§92.101)* that prohibits discrimination on the basis of sex stereotypes; sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; and gender identity. While the terms "gender identity" and "transgender status" are often used interchangeably, there have been instances in which those seeking to permit discrimination against transgender people have justified it by pressing distinctions between the two concepts. Therefore, explicit language is needed to prevent this discrimination and consistency throughout the final rule is important. **CHCANYS recommends also including "transgender status" in § 92.206(b)(1), (b)(2) and (b)(4), and in §92.207(b)(3).**

CHCANYS supports HHS extending additional protections to include discrimination based on an individual's relationship or association, per §92.209. This is consistent with longstanding interpretations of other antidiscrimination laws, which cover discrimination based on an individual's own characteristics or those of someone with whom they are associated or with whom they have relationship. As noted in the preamble, certain protected populations, including LGBTQ people, are particularly susceptible to discrimination based on association. It is important that the final rule make clear that this kind of associational discrimination is within the ambit of the rule's protections.

CHCANYS is immensely supportive of this expansive definition of discrimination under this rule, as this will protect LGBTQ patients experiencing discrimination in health care settings, especially in certain states where access to essential services is threatened. Many states lack explicit LGBTQ discriminations in health care, and CHCANYS appreciates the Administration's intention to return 1557 protections back to language in the 2016 rule and in many instances, expand upon those protections.

Nondiscrimination in Health Insurance Coverage and Other Health-Related Coverage (§92.207)

CHCANYS is supportive of the proposal in §92.207, as this would prohibit discrimination against patients with Medicaid, Medicare Part B, and coverage through the federal marketplace. For decades, health centers have developed extensive partnerships with state Medicaid agencies and nearly 59% of New York's health center patients are Medicaid beneficiaries. Additionally, about 7% of our patients have Medicare and 22% have private insurance.

While benefits for Medicaid and Medicare are continuing to become more robust and inclusive, beneficiaries have limited options for providers, facilities, and services depending on which state they are located in. Medicare and Medicaid beneficiaries deserve access to equitable, quality health care, regardless of their income or location. The combination of discrimination and social determinants of health can discourage patients from seeking primary care and routine services. CHCANYS appreciates HHS taking steps to protect patients with insurance coverage that falls under the definition of Federal Financial Assistance, this includes the design of health insurance benefits, marketing practices, and coverage provisions.

Health centers across the country wipe away millions of dollars of "bad debt" for those who lack the financial means to pay for the care they need. This frequently happens when patients seek care that falls outside of their insurance coverage because of their gender identity or reproductive status. Oftentimes, patients cannot afford to pay out of pocket, thus preventing them from receiving necessary services. However, patients know they can receive the care they need at their local health center. Living true to the health center mission, our patients do not have to choose whether they can afford paying for the care they need or paying for life essentials such as food, housing, or transportation.

CHCANYS encourages HHS to finalize §92.207 to provide equal protections to all patients and create equitable discrimination protections for all types of health insurance coverage. Historically, health plans and insurance companies have implemented discriminatory practices that impact applicants and enrollees based on sex, race, color, national origin, age, and other intersecting identities. For example, private and public insurers have been found to discriminate based on relationship status and sexual orientation through policies that require single people or those in non-heterosexual relationships to pay out of pocket for certain reproductive health services. Given these circumstances, patients face difficult decisions on where to obtain care and have little recourse if they experience discrimination in seeking care.

CHCANYS also strongly support OCR'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 how the Part B program has evolved, the fact that most Part B providers are already receiving other forms of FFA, and the clear intent of the § 1557 statute. It will eliminate confusion for older adults and people with disabilities and 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 underserved communities who face the most discrimination and barriers, as many Medicare providers serve people with other forms of insurance.

CHCANYS agrees with HHS' judgment that the statutory text of Section 1557 is clear: Congress intended that the law apply to these entities and address these issues. **Thus, CHCANYS strongly supports HHS' restoration of and improvements to § 92.207, including its inclusion of specific forms of prohibited discrimination.**

Specific Applications to Health Programs and Activities - *Equal Program Access on the Basis of Sex (§92.206)*

CHCANYS supports the proposed rule's §92.206 that ensures patients have equal program opportunity on the basis of sex. We also strongly agree with its extension to nondiscrimination in the coverage of gender affirming and transition-related care. For years, studies have shown disparities in accessing care for Transgender individuals. Transgender and Gender Diverse individuals commonly face insurance-related obstacles to obtain clinically appropriate care. These disparities only multiply for Black, Indigenous, and other Transgender People of Color, as well as Transgender People with disabilities. By finalizing this provision, this will help address health disparities among the LGBTQ community by prohibiting denials to programs based on their gender.

Nondiscrimination in the Delivery of Health Programs and Activities Through Telehealth Services (§92.211)

CHCANYS is very supportive of OCR's proposal to explicitly include telehealth in the nondiscrimination provisions, as it is important that nondiscrimination languages align for this rising modality of care. Health center patients have greatly benefitted from access to services through telehealth during the COVID-19 pandemic; in 2021, health centers nationally conducted over 26 million virtual visits. Health centers offer a variety of services to their patients via telehealth. In 2021, 54% of visits were for mental health, 31% of visits addressed substance use disorder, 27% of visits were for enabling services and 18% of visits were medical visits. Offering the option of telehealth to patients is a way to move past social determinant of health barriers that patients face when trying to access health care, such as lack of reliable transportation and lack of childcare options.

However, telehealth has not been equitable for Limited English Proficient (LEP) patients and people with disabilities, and service platforms are not yet made available at all to people with disabilities or people with limited English proficiency. As a basic step, CHCANYS recommends OCR to require telehealth platforms be able to include a third party such as an interpreter or use of auxiliary aids and services. Second, all communication about telehealth that occurs prior to a telehealth appointment – including scheduling, information about system requirements and testing connections, appointment reminders, and log-on details – must be accessible to people with LEP and disabilities. Similarly, platforms should be adapted to meet the needs of people who are autistic, deaf or hard of hearing, blind, deaf/blind, movement impaired, or otherwise have difficulty in communicating via traditional telehealth models. Before the telehealth interaction, providers should assess for visual, cognitive, intellectual, mobility as well as functional needs to maximize the patient's health care experience. CHCANYS recommends that OCR consider including notification of telehealth services in the list of electronic communications that must include the notice of availability of language assistance services and auxiliary aids and services. By adopting these recommendations, health care facilities, including health centers, will be equipped with the necessary tools and technology to continue to offer high quality, accessible care through telehealth.

Meaningful Access for Limited English Proficient Individuals (§92.201)

CHCANYS supports the provisions related to meaningful access. It has been long recognized that the denial of adequate language services to LEP individuals constitutes discrimination on the basis of national origin. Specifically, there are clear intersections between LEP status and race and/or ethnicity. With many LEP individuals being racial/ethnic minorities, lacking adequate language services perpetuates discrimination against people of color by health care providers. This discrimination felt by patients may deter them from seeking critical health care services, leading to adverse health outcomes and decreased trust in the health care system. Therefore, improving meaningful access for LEP individuals will be an important tool in enhancing health equity by allowing patients to access and understand health care services in a language they prefer.

With over 14,000 individual sites across the US, health centers serve a large patient population who speak a variety of languages. A large part of the health center program is to have translation services to serve our patients and meet community needs. In 2021, 28% of New York's health center patients preferred a language other than English. Health centers will continue to prioritize hiring more translators and interpreters to better serve LEP individuals to ensure patients understand the care and services they receive to meet the growing need for our patient population.

CHCANYS also supports the clarification in the 2022 Proposed Rule related to the restricted use of certain persons to interpret or facilitate communication. The prior regulations recognized that an LEP individual cannot be required to provide their own interpreter, and that a minor can only be used to interpret in an emergency and that an adult accompanying an adult should not act as an interpreter without the person's consent or in an emergency. The 2022 Proposed Rule adds an expectation that in an emergency situation, the reliance an accompanying adult or minor should be “a temporary measure”. When health care facilities do not have interpreter services, the burden can fall on the individual patient or their family, especially children. This benefit will provide protections under these circumstances if there is an issue with the patient receiving proper care due to the language barrier.

Effective Communication for Individuals With Disabilities (§92.202) and Accessibility of Information and Communication Technology for Individuals With Disabilities (§92.204)

CHCANYS supports §§ 92.202 and 92.204 on effective communication and accessible information and communication technology (ICT) requirements for people with disabilities. Health centers are the largest primary care network in the United States and 1 in 5 Medicaid beneficiaries is a health center patient. Medicaid is the primary insurer for people with disabilities, making health centers a primary site for all populations to access those services. Primary care providers at health centers take the time to build a relationship with patients over time, allowing them to be well-positioned to provide whole person, targeted care and address overall persistent health needs. Health centers always strive to meet patients where they are depending on their abilities and health needs and will continue to utilize communication services and make information easily available and accessible to patients with disabilities.

Designation and Responsibilities of a Section 1557 Coordinator

CHCANYS supports the new provision proposed in §92.7 that allows covered entities to assign one or more designees to carry out some responsibilities of the Section 1557 Coordinator. Having a 1557 Coordinator is crucial to have a designated person to track requirements and create required systems/trainings related to nondiscrimination discrimination. The COVID-19 pandemic has placed an incredible strain on an already exhausted health care workforce, with workers spread thin; compliance with these provisions would fall through the cracks if health care facilities were not intentional on having a team together to address it. Health centers are struggling to maintain an adequate workforce: 68% of health centers reported losing 5-25% of their workforce in mid-2021, with employees citing competition from other employers and pandemic stress as the most common reasons for departing. CHCANYS appreciates OCR’s flexibility to some providers and facilities, like health centers, to spread 1557 responsibilities across multiple staff to ensure maximum compliance. By having §92.7 in place, it holds all health care facilities accountable, especially in states that are not prioritizing health equity.

Data Collection Proposal/Request for Information

In response to the request for comment on the data collection piece, **CHCANYS encourages HHS to utilize existing data collection systems to minimize provider burden.** The request for information mentions whether some covered entities, as recipients of Federal financial assistance, are already collecting disaggregated demographic data in their health programs and activities, and in what systems as well as at what cost. All FQHCs are required to submit data through an annual reporting system called the Uniform Data System (UDS). FQHCs report data on utilization, patient demographics, insurance status, managed care, prenatal care and birth outcomes, diagnoses, and financing.

Beginning in 2024, HRSA will implement an enhanced UDS system, UDS+, to allow health centers to submit CY2023 data. UDS+ will move from patient-oriented tables, aggregated at the health center level, to more patient level-data. The data will show the breakdown of most outcomes by demographics and incorporate social drivers for the need for social services by demographics. Health centers will continue to report data that includes race, ethnicity, language, gender, gender identity, sexual orientation and age, which are suggested in this data collection section. While disability status is not currently slated to be collected in UDS+, we know that HRSA is working closely with ONC on data standards and that disability is one of the elements in United States Core Data for Interoperability v3. Its inclusion in the future would satisfy the data ONC wants in its goals to improve equity.

In terms of reporting burden, health centers are happy to provide this data to HRSA, which takes approximately 238 total hours a year to fully complete the UDS report. Besides reporting these data, health centers are ensuring they come into compliance with Fast Healthcare Interoperability Resources (FHIR) to allow healthcare information to be easily exchanged between by implementing electronic health records (EHR) platforms. Given these considerations, we appreciate HHS to allow FQHCs to opt out of submitting data and encourage OCR to work with HRSA to access these valuable disaggregated data.

Thank you for your consideration of these comments. If you have any questions, please contact Marie Mongeon, Senior Director of Policy: mmongeon@chcanys.org.