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August 17, 2021

RADM Felicia Collins
Office of Minority Health
Department of Health and Human Services
1101 Wootton Parkway, Suite 100
Rockville, MD 20852

Submitted via <https://www.regulations.gov>

RE: Best Practices for Advancing Cultural Competency, Language Access and Sensitivity Toward Asian Americans and Pacific Islanders (86 FR 37757; FR Doc. 2021-15168)

Dear Director Collins:

The National Health Law Program, founded in 1969, protects and advances health rights of low-income and underserved individuals and families. We advocate, educate and litigate at the federal and state levels to advance health and civil rights in the U.S. The National Health Law Program (NHeLP) defends and fights to expand health and civil rights of those most in need and those with the fewest resources. We strive to give a voice to low-income individuals and families in federal and state policy making, promote the rights of patients in emerging managed-care health care systems, and advocate for a health care system that will ensure all people have access to quality and comprehensive health care. NHeLP appreciates the opportunity to comment on the U.S. Department of Health and Human Services Office of Minority Health (OMH) request for information: *Best Practices for Advancing Cultural Competency, Language Access and Sensitivity Toward Asian Americans and Pacific Islanders*.

We draw upon our 50-plus years of experience working to improve Medicaid and enforce civil rights in responding to the RFI. With the comments provided below, we aim to inform the development of guidance describing best practices for advancing cultural competency, language access, and sensitivity toward Asian American, Native Hawaiian and Pacific Islander (AANHPI) communities in the context of the Federal Government's COVID-19 response.

I. BEST PRACTICES FOR FEDERAL GUIDANCE ON COVID-19 RESPONSE IN AANHPI COMMUNITIES

Advancing Cultural Competency & Language Access

Existing federal laws and regulations require protections for limited English proficient (LEP) communities, which is critical for the 25 million Americans, including over 6 million Asian Americans and over 100,000 NHPs, who speak English less than very well.¹ These protections include Title VI of the Civil Rights Act of 1964, Executive Order 13166, Section 1557 of the ACA and the Language Access Plans generated by federal departments and agencies, including the Department of Health and Human Services (HHS). In practice, however, few documents are translated into other languages and interpreters are rarely available. As a result, community-based organizations are left with filling the void of translating, outreaching, and disseminating critical information.

Currently, CDC has translated their COVID-19 website into only four languages, while their print resources are translated inconsistently.² In a survey APIAHF conducted of 45 community-based organizations, 89 percent reported needing in-language and culturally appropriate resources about the virus.³ Further, a report from ProPublica⁴ raises serious concerns that language barriers could lead to rationing of care, undermining civil rights and the HHS Office

¹ APIAHF analysis of American Community Survey, 2018 data.

² See "CDC Resources in Other Languages than English," available at: <https://wwwn.cdc.gov/pubs/other-languages?Sort=Lang%3A%3Aasc>.

³ "What Asian American, Native Hawaiian, and Pacific Islander Community Organizations Need in the Face of the COVID-19 Pandemic," APIAHF (July 2020). Available at: <https://www.apiahf.org/resource/covid-19-need-to-know/>.

⁴ Kaplan, Joshua, "Hospitals Have Left Many COVID-19 Patients Who Don't Speak English Alone, Confused and 'Without Proper Care,'" ProPublica (March 31, 2020). Available at: <https://www.propublica.org/article/hospitalshave-left-many-covid19-patients-who-dont-speak-english-alone-confused-and-without-proper-care>.



for Civil Rights bulletin issued March 28, 2020.⁵ Moreover, the lack of translated materials from credible government sources leaves LEP communities especially vulnerable to misinformation.

On April 30, 2021, NHeLP filed [a complaint](#) with the U.S. Department of Health and Human Services Office for Civil Rights (OCR), the Federal Emergency Management Agency (FEMA), and the Department of Homeland Security Office for Civil Rights and Civil Liberties contending that federal, state, and local agencies are failing to provide individuals with limited English proficiency (LEP) meaningful access to COVID services. According to the complaint, this failure violates numerous federal laws, regulations, and guidance and makes access to COVID-19 testing, vaccines, treatment, and contact tracing significantly more difficult for the nation's nearly 25 million people with LEP. The specifics of the complaint were informed by information provided to the National Health Law Program by more than 35 organizations and individuals, nationwide. We urge OMH to review this complaint, incorporate it in its entirety into the record for this RFI, and to review the specific recommendations we provide.

Although NHeLP has made efforts to help LEP persons, the rights of LEP persons continue to be violated when they do not receive accurate and timely information in a culturally and linguistically accessible manner about COVID-19 and access to life-saving treatment, testing, and prevention measures. This concern also extends beyond COVID-19, as access to government services has been an ongoing issue for LEP communities. The ongoing concerns of language access and culturally appropriate services question whether current agency language access guidance and protocols are effective and whether such guidance should be reevaluated.

HHS should take action to enhance reimbursement of interpreter services as providers continue to struggle during the pandemic. See Shivani A. Shah et al., *Reconsidering Reimbursement for Medical Interpreters in the Era of COVID-19*, JAMA NETWORK (Oct. 12, 2020), <https://jamanetwork.com/channels/health-forum/fullarticle/2771859>. When CBOs are being called upon, they should be appropriately recognized and compensated.

⁵ "OCR Issues Bulletin on Civil Rights Laws and HIPAA Flexibilities That Apply During the COVID-19 Emergency," U.S. Department of Health and Human Services, Office for Civil Rights (March 28, 2020). Available at: <https://www.hhs.gov/about/news/2020/03/28/ocr-issues-bulletin-on-civil-rights-laws-and-hipaa-flexibilities-that-apply-ding-the-covid-19-emergency.html>.



RECOMMENDATIONS:

- Develop an emergency preparedness guide for state public health, emergency management, and Medicaid directors, similar to the joint agency guidance on Title VI and emergency preparedness, response, mitigation and recovery, https://www.dhs.gov/sites/default/files/publications/20_0207-guidance-emergency-preparedness-compliance.pdf.
- Create an Office of Language Access Services at HHS that oversees the administration and monitoring of language services across programs and contracts.
- Add a requirement for federal fund applicants to develop a language access plan in their grant proposals with appropriate funding.
- Educate federal fund recipients on how to conduct ongoing quality assessments and reviews of their language services.
- Submit an appropriations request for HHS to develop and pilot a universal icon to symbolize language accessibility on signage, written documents, websites and other public facing materials.

Advancing Data Equity and Disaggregation

Since the beginning of the COVID-19 pandemic, the lack of comprehensive and accurate data has exposed the country's challenges in identifying those most impacted and developing targeted and appropriate interventions. The data that have been available have been key in helping us understand which communities we need to prioritize in our response to the virus.

The collection of high quality data, including on smaller populations within AANHPI communities as well as individuals with multiple identities, is a critical first step in understanding and eliminating disparities in healthcare access and health outcomes and ensuring compliance with nondiscrimination requirements. The dearth of comprehensive, disaggregated accurate demographic data of AANHPI individuals hinders our ability to fight discrimination, health disparities and structural racism. OMH should work with other agencies within HHS, and particularly OCR, to require the collection of demographic data so that covered entities can document compliance with federal laws and demonstrate that they do not



discriminate. Having accurate data also helps covered entities plan how to provide language services and auxiliary aids and services.

While the existence of health disparities has been well documented, the complex factors that contribute to and mitigate against them are still not fully understood. In part, this is due to a lack of high quality, large scale, and easily available data. For example, data on smaller racial and ethnic groups, particularly within the AANHPI community, is often not extensive enough to lend itself to meaningful analysis. Similarly, data is often not available for intersecting sub-populations that might experience multiple barriers to access.

OMH should work within HHS to adopt standardized categories and definitions for all demographic variables. Racial, ethnic and preferred language data should be collected at a granular level to allow for disaggregation, particularly for AANHPI communities and allow for inclusion of Middle Eastern and Northern African (MENA) populations.

Demographic data can help researchers, policy makers, public health workers, and healthcare practitioners target interventions to the populations that need them most, tailor interventions to the specific needs of a community and prevent discrimination. Further, health disparities data collection is crucial for measuring quality. Broad collection of demographic data is integral to understanding whether a particular program is upholding civil rights requirements and improving the health outcomes of all groups. Without this data, average improvement in the health outcomes could mask a lack of improvement or even deterioration in outcomes for a specific population.

Demographic data collection is especially important during COVID but also as we move towards a health care payment system that rewards quality rather than quantity. The ACA recognizes the central role of data in quality care, and appropriately requires demographic data collection as a component of federal quality reporting requirements.

As we have seen the rise of hate crimes against AANHPIs during COVID, we must also ensure that data collected is maintained safely and securely by the appropriate entities. Strict standards must be adopted to ensure that data cannot be used for negative actions such as immigration or law enforcement, redlining or targeting of specific groups. Individuals must feel comfortable disclosing personal information. We encourage OMH to work within HHS to ensure that the privacy protections applied to demographic data comply with the privacy and security standards set forth in ACA Section 3101, which built upon the privacy protections



required by HIPAA. Individuals should be made aware of their privacy protections and rights – including those granted under applicable state laws as well as the ACA – and have a clear understanding of why demographic data is being collected and who will have access to which forms of information.

While all covered entities must be required to ask for data, individuals' responses must be voluntary and should be self-reported to ensure accuracy. It is critical to train relevant staff on the collection of demographic data, including how to explain why data is being collected. The Health Research and Educational Trust (HRET) developed [a toolkit](#) for collecting race, ethnicity and language data after testing different rationales for collecting this data. We recommend that OMH work with other HHS agencies to develop a similar toolkit focused on collecting demographic data beyond patient care settings and beyond race, ethnicity and language.

OMH should also work with CCIO and CMS' Office of Communication to improve collection of language data in marketplaces and Medicare. Currently, healthcare.gov only collects language data of the household contact, who may not even be a member of the household. To both adequately plan for the language needs of LEP individuals as well as ensure nondiscrimination, healthcare.gov should collect language data of **all** individuals applying for coverage. CCIO should also evaluate whether state marketplaces collect language data of all applicants. With regard to Medicare, the Social Security Administration has limited language data, primarily collecting it in field offices in a way that does not update SSA's primary enrollee database. Again, the lack of comprehensive data collection means that Medicare providers may not know the language needs of their patients in advance, making it more challenging to plan for and provide language services.

RECOMMENDATIONS:

- Ensure that, when collecting racial and ethnic data, data on NHPI communities are separated from Asian American data as guided by the 1997 OMB standards. We emphasize that federal departments and agencies should consider any OMB standards as minimum standards, using the additional disaggregation recommended by HHS under ACA section 4302 and by the 2015 ONC standards for certified electronic health records.



- Employ standards set in ACA Section 4302 and by the ONC in 2015 allowing HHS to support even more granular disaggregation when appropriate, and continue to work with state and local governments to support additional disaggregation where there are more diverse racial and ethnic subgroups. Disaggregation by more granular race and ethnicity categories is essential to understanding inequities and disparities and advancing equity.
- Collect language data of all applicants on healthcare.gov applications and ensure state marketplaces are doing the same.
- Develop and implement a plan to improve race, ethnicity and language collection of Medicare applicants and enrollees.

Advancing Sensitivity & Mitigating Racial Discrimination Against AANHPI Communities

Asian American⁶ communities are experiencing the dual blow of COVID-19 disparities and misplaced blame for the pandemic. Use of xenophobic rhetoric, like “China Virus”, “Wu Han Virus”, and “Kung Flu” by the previous administration and other high-ranking officials comes at the cost of the health and safety of Asian American communities.

Since March 2020, AANHPI organizations have documented over 9,000 hate incidents targeting AANHPIs.⁷ In a recent survey conducted by APIAHF, 70 percent of AANHPIs believe discrimination against their communities has become more common than it was before the pandemic, with nearly 50 percent reporting that they or an immediate family member have experienced at least one form of discrimination since the advent of COVID-19.⁸

The rise in violence against Asian American communities is illustrated in the reports of violent attacks on Asian American elders throughout the country, several of whom died from injuries sustained from these hateful acts of violence. Our hearts were further broken by the recent mass shooting in the Atlanta-area where the victims were predominantly Asian American

⁶ Here, the term “Asian American” is intentionally distinguished and disaggregated from “AANHPI.”

⁷ Aggie Yellow Horse, Ph.D., et al. “Stop AAPI Hate National Report 3/19/20-6/30/21”, Stop AAPI Hate (Aug. 12, 2021). Available at: <https://stopaapihate.org/wp-content/uploads/2021/08/Stop-AAPI-Hate-National-Report-Final.pdf>.

⁸ “Asian Americans, Native Hawaiians, and Pacific Islanders on COVID-19 and Getting Vaccinated: Survey Findings Summary,” APIAHF (July 21, 2021). Available at: <https://www.apiahf.org/resource/nationwide-survey-of-aanhpi-on-covid-19/>.



women, which was followed by the mass shooting in Indianapolis where the victims were predominantly Sikh Americans.⁹

While we applaud the Biden-Harris Administration's efforts condemning racism towards Asian American communities and Congress' relatively swift bipartisan passage of the COVID-19 Hate Crime Act, there is still much work to be done to address the systemic causes of racism and hate crimes. The impact of the dual blow of COVID-19 and the rise of hate incidents have caused some to forgo being tested or to seek care due to the COVID-19 stigma attached to Asians and the fear of being attacked.¹⁰ The implication of these fears may give reason to the low rate of COVID-19 testing and disproportionate rates of COVID-19 related deaths in AANHPI communities.¹¹

RECOMMENDATIONS:

- Provide grants or contracts with community-based organizations in relationship with LEP and immigrant communities for the purposes of culturally tailored outreach, language assistance and connections to services.
- Translate documents into at least the 20 languages identified in the FEMA language access plan, as well as other languages after an assessment of local need.
- Invest in culturally appropriate victim-centered support services for victims of hate incidents, including mental health services.

⁹ Bill Chappell, Vanessa Romo, "Atlanta Shooting Suspect Charged In Spa Killings," NPR (March 17, 2021). Available at: <https://www.npr.org/2021/03/17/978141138/atlanta-shooting-suspect-is-believed-to-have-visited-spas-he-targeted>; Jeannette Muhammad, Emma Bowman, "Indianapolis Sikh Community Mourns 4 Of Its Members Killed In Shooting," NPR (April 18, 2021). Available at: <https://www.npr.org/2021/04/17/988382654/indianapolis-sikh-community-mourns-as-4-of-its-members-are-killed-in-shooting>.

¹⁰ Marco della Cava, Asian Americans in San Francisco are dying at alarming rates from COVID-19: Racism is to blame, USA Today (Oct. 21, 2020), available at: <https://www.usatoday.com/in-depth/news/nation/2020/10/18/coronavirus-asian-americans-racism-death-rates-san-francisco/5799617002/>.

¹¹ Brandon Yan, Andrea L Hwang, Fiona Ng, et al., "Death Toll of COVID-19 on Asian Americans: Disparities Revealed," Journal of General Internal Medicine (2021). Available at: <https://doi.org/10.1007/s11606-021-07003-0>.



II. IMPLEMENTATION CONSIDERATIONS & IDENTIFYING ADDITIONAL BEST PRACTICES

The COVID-19 pandemic highlighted the importance of community-based organizations and community health centers in outreaching to, educating, preventing, assisting, and helping communities heal from COVID-19. Without these community-based organizations and their teams of organizers, community health workers, social workers, etc., the effects of the COVID-19 pandemic would likely have been even more devastating, especially for communities of color and other medically underserved communities.

Community-based organizations and community health centers are uniquely positioned to address and identify the needs of some of the most underserved and hard to reach populations. Thus, engaging with community-based organizations, health centers and other AANHPI serving organizations is pivotal in the success of implementing federal guidance and identifying best practices.

Moreover, the experience and expertise of the community-based organizations and health centers often make them effective conduits of culturally appropriate and linguistically accessible community outreach and education on federal laws and guidance and the rights of community members. As such, the OMH should create outreach materials to inform community leaders and the communities they serve about the federal guidance and what accessing government funded services should look like.

RECOMMENDATIONS

- Engage with community- based organizations, community health centers, health care providers, academic institutions, ethnic media, and other organizations and stakeholders to identify best practices and to bring awareness to federal laws and guidance materials. These engagement opportunities should include regular stakeholder meetings with the COVID-19 Health Equity Task Force.
- Distribute federal guidance, best practices, and other relevant materials to community organizations in a culturally appropriate and linguistically accessible manner. This process can help communities understand their rights and improve health outcomes.



III. SUPPORT FOR IMPLEMENTATION

Culturally competent and linguistically accessible services and care are bound to one another. But it is within the boundaries of language access protections where HHS and OMH can support the implementation of best practices and other guidance. Existing federal law requires protections for LEP communities. These protections include Title VI of the Civil Rights Act of 1964 and Section 1557 of the ACA, in addition to precedents set in Executive Order 13166. Similar to the HHS guidance on “long COVID,” protections for AANHPI communities must be reinforced by the laws and precedents already in existence.¹²

Title VI of the Civil Rights Act of 1964 (Title VI) provides that no person shall be subjected to discrimination on the basis of race, color, or national origin under any program or activity that receives federal funding. Executive Order 13166 further validated the nexus between language and national origin by explaining its goal “to improve access to federally conducted and federally assisted programs and activities *for persons who, as a result of national origin, are limited in their English proficiency.*”¹³

Within the healthcare context, Sections 1557 of the Affordable Care Act prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs and activities.¹⁴ In 2016, HHS Office for Civil Rights (OCR) issued a final rule under Section 1557 explaining that the prohibition on national origin discrimination requires covered entities to take reasonable steps to provide meaningful access to LEP individuals who are eligible to be served or likely to be encountered within the entities’ health programs and activities, including all programs operated by HHS.

In practice, however, due to lack of available government resources and enforcement, vital print resources are not always translated into other languages and interpreters are rarely available. Community-based organizations and community health centers often still fill the void in translating vital information for LEP community members, often without being reimbursed for these services.

¹² “Guidance on ‘Long COVID’ as a Disability Under the ADA, Section 504, and Section 1557,” US Dept. on Health & Human Services Office of Civil Rights, and US Dept. of Justice Civil Rights Division (July 26, 2021).

¹³ “Improving Access to Services for Person with Limited English Proficiency,” Executive Order 13166 (Aug. 11, 2011).

¹⁴ Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31375 (May 18, 2016).



For best practices guidance to be implemented, covered entities must be aware of laws and regulations that support language access, and the health and legal consequences of noncompliance. Although HHS has made progress in addressing language access and cultural competency by promoting such services, enforcement of the actual laws that drive language access guidances and trainings for best practices still needs to be strengthened.

In particular, we urge HHS to issue technical guidance regarding the use of automated translation software and other web-based technologies. The increased reliance on web-based technologies to translate written documents, websites, and other communication modalities necessitates stand-alone guidance from HHS/OCR and other federal agencies. The guidance should ensure recipients clearly understand why they should not rely on automated translation software alone for websites and provide technical, step-by-step instructions on *how* to overcome the limitations of automated translation software. Recipients should also be educated about the differences between using automated translation software as a tool for translating written documents and when using it to translate a website. As a best practice for stakeholder engagement, OMH could facilitate a process for advocates and other key stakeholder groups to review and provide feedback on the guidance before it is finalized.

After completion of the guidance, we recommend HHS work with OMH to conduct technical assistance trainings for existing recipients and entities interested in applying for federal funding.

Recommendations

- Within the federal guidance or in separate documents, OMH in conjunction with OCR should explicitly state the legal backing for language access. OMH should work with OCR to provide language access oversight standards for all agencies granting funds to ensure they and recipients of federal funding are complying with civil rights protections.
- OMH should work with HHS to develop standards for contracts and grantmaking that require all applications for HHS funding include explicit information about how applicants will meet the needs of LEP individuals. Applications and funding contracts should require development and implementation of language access plans by applicants and budget line items to ensure effectuation. Applicants that do not provide information on how they will serve LEP individuals should receive higher scrutiny and



evaluated to determine if the applicant has the relevant expertise and resources to comply with federal law as well as grant requirements.'

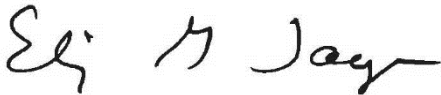
- HHS should issue technical guidance regarding the use of automated translation software and other web-based technologies. Implementation of the guidance should include working with OMH and other agencies to conduct outreach and trainings to federal fund applicants and recipients about the technical guidance.

IV. CONCLUSION

We greatly appreciate the opportunity to provide these comments. Data equity and disaggregation, language access, support to community-based organizations, and the enforcement of civil right laws remain important factors ensuring the federal government can better serve AANHPI communities.

If you have any further questions or concerns, please contact Mara Youdelman, youdelman@healthlaw.org or (202) 289-7661.

Sincerely,



Elizabeth G. Taylor
Executive Director

