

October 3, 2022

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

Re: RIN 0945-AA17
Nondiscrimination in Health Programs and Activities

Dear Acting Director Fontes Rainer:

The American Translators Association appreciates the opportunity to comment on the Department of Health and Human Services' Office for Civil Rights (OCR) proposed rule, Nondiscrimination in Health Programs and Activities (hereinafter "2022 Proposed Rule")

The American Translators Association (ATA) is the largest professional association of interpreters and translators in the United States, with more than 8,500 members who work in over 50 languages. ATA advocates for nondiscrimination and language access at every level and in every industry, and our members are key facilitators in communications between individuals with limited English proficiency and the US legal system, healthcare system, federal government, and more.

Given our focus on language access, we have focused our comments only on those parts of the 2022 proposed rule.

Overall, we strongly support the provisions related to language access for individuals with limited English proficiency (LEP). Language access is essential to ensuring effective communication between individuals and the healthcare system, without which individuals with limited English proficiency may not enroll in programs for which they are eligible, may not receive timely or comprehensive healthcare, and may not know their rights to free, timely and competent language services.

Definitions

Qualified Interpreters

The 2022 Proposed Rule includes definitions for qualified interpreter for a limited English proficient individual, qualified translator, and qualified interpreter for an individual with a disability. ATA appreciates and supports the inclusion of these definitions; However, ATA also recommends that the definition under (3) is able to interpret effectively, accurately, and impartially, both receptively and

expressly, to and from such language(s) and English... be amended to (3) is able to interpret effectively, accurately, and impartially, both receptively and expressly, between foreign language(s) and English. This would allow the use of relay, which is [the practice of interpreting from one language to another through a third language](#), a reality for many Indigenous-language interpreters in the U.S. In the Greater Los Angeles area alone, there are more than 250,000 Zapotec speakers. Nearly all Zapotec patients require relay interpreting provided by both a Zapotec/Spanish interpreter and a Spanish/English interpreter.

ATA further recommends the inclusion of the following definition for relay interpreting:

Relay interpreting means a form of interpreting used when speech is rendered from an intermediate language rather than directly from the source language. For example, from Spanish to ASL, there would be a Spanish to English interpreted message, which the ASL interpreter renders from English to ASL. This applies to all modes of interpreting: simultaneous, consecutive, and sight translation.

We recommend that OCR amend the definition of qualified interpreter for an individual with a disability to more closely align with that for qualified interpreter for a limited English proficient individual. That is, the definition of interpreter for an LEP individual has three parts that are not necessarily identical to the definition of an interpreter for a person with a disability. We believe a qualified interpreter for a person with a disability should demonstrate proficiency.

Further, any “interpreter for an individual with a disability” should communicate “without changes, omissions, or additions and while preserving the tone, sentiment, and emotional level of the original statement” and adhere to generally accepted principles of ethics, including client confidentiality. These additions will provide alignment between the different types of interpreters and those providing other communication assistance and recognize that similar standards should apply whether an interpreter is interpreting for an LEP individual or a person with a disability.

Finally, ATA recommends that a certification requirement for languages for which an existing pathway for certification exists be phased in over several years. The regulation should include the following language regarding certification: “Additional evidence of interpreter qualification includes individual certification by third parties, such as the [Certification Commission for Healthcare Interpreters](#) and the [National Board of Certification for Medical Interpreters](#).” Certification by employers, such as language service companies, does not meet the same standards across the board, whereas national certification is a reliable standard. For languages with no certification available, both national certification bodies mentioned above have a path to verify that candidates have a high potential for accurate interpreting.

When language barriers among medical staff and patients are eliminated, there is much better situational comprehension and patient satisfaction. In addition, the use of a qualified interpreter reduces hospital stays and readmission rates. A study published by Allison Squires, PhD, RN, FAAN, associate professor at NYU Rory Meyers College of Nursing (October 27, 2021), established that only 20% of non-English-speaking patients received services in their preferred language, resulting in a higher hospital readmission rate than English-speaking patients.

When family and friends are used as *ad hoc* interpreters, errors in understanding and communication occur. This creates a safety risk for the patient and a liability issue for the medical provider or healthcare institution. In addition to reducing the risk of misunderstanding, a qualified interpreter will ensure regulatory compliance, maximize reimbursements for all parties involved, and improve patient

satisfaction. Look no further than the [case of Willie Ramirez](#) for evidence, or the numerous studies and examples that point to the [high cost of language barriers in medical malpractice](#).

Because of issues of confidentiality, patients may not speak frankly with a physician when family or friends are acting as interpreters. An ATA member reported that in one interpreting encounter, she was interpreting for a 16-year-old female patient from Afghanistan. Before the interpreter arrived, the provider asked the patient's brother to interpret while their father was present. He told the brother to ask the patient when her last period was, whether she was sexually active, and other questions of this nature. She replied, "no" to all of the questions. When our member was finally called to interpret, she heard a very frustrated doctor telling the patient, "You are not pregnant; the test was negative." The patient responded that of course she knew she was not pregnant. The patient told our member that she would never speak about her period in front of her brother or father, so the doctor was about to prescribe her hormones for missing her periods. The presence of a qualified interpreter solved the problem and resulted in proper care. In a similar situation, an Afghan woman was suffering from a UTI, but because the previous interpreter had been male, she did not feel comfortable disclosing the nature of her problem. She suffered for another two months before going back to the doctor, where our female member served as her interpreter, and she received proper care.

It can be difficult to determine whether bilingual/multilingual staff are qualified to provide services directly in a non-English language. ATA members have transcribed and translated interviews interpreted by bilingual staff in which there are frequent misunderstandings that lead the conversation in unexpected directions. It is important that the person providing interpreting services knows and understands the specific terminology in the target language. Time is of the essence in a medical setting, and it is not possible to stop the interpreting process to research a term. It is necessary to have a qualified professional capable of conveying the message accurately.

Being familiar with the ethics and protocols of interpreting is essential. A bilingual person may not have the technical knowledge necessary to perform this task and may not know the necessary interpreting protocols. The ethics of the aforementioned healthcare interpreting certification bodies provide guidelines for the conversation between patient and provider to be fluid and transparent.

Though many interpreters are biliterate, oral and written communication have different standards. Interpreters are certified in rendering oral messages, with the protocols and expectations of oral communication. Translators are vetted in written translation and are tested to verify that they are proficient at finding the right equivalent expression in writing. This includes details as seemingly minor as punctuation, but given differences in the treatment of marks as simple as commas versus periods for decimals, especially when it comes to conveying information like dosing medication, the impact can be profound.

There are language proficiency tests available to verify the competence of staff members in communicating in languages other than English. The most reliable tests are evaluated by two raters whose results are checked on a regular basis. When the two raters do not agree on the results, a third rater is called to evaluate the test results.

Machine Translation

ATA also strongly supports the inclusion of a definition of machine translation and recognition that machine translation of critical information [must be reviewed by a qualified human translator](#).

In a study published in [JAMA Internal Medicine](#), Elaine C. Khoong, MD, MS and colleagues assessed the use of GT to translate emergency department (ED) discharge instructions into Spanish and simplified Chinese. They found that in 2% of Spanish and 8% of Chinese discharge instructions, inaccurate translations had the potential to cause **clinically significant harm**. These were mostly due to grammar or typographical errors in original written English instructions, which would readily have been overlooked or understood by those who can read English text.

Our members have reported seeing providers use Google Translate to provide LEP individuals with a meaningless translation of a consent form that they then ask them to sign. In the case of one member, who works with Afghan refugees, the LEP patient is also often illiterate or not literate enough to read such a form, and without the presence of an interpreter, the patient cannot inform the provider and provide consent. The presence of an interpreter is crucial in situations like these.

Medicare Part B

ATA strongly supports OCR's proposal to treat Medicare Part B payments as federal financial assistance (FFA) and Part B providers and suppliers as recipients under Section 1557, Title VI, Title IX, Section 504, and the Age Act. This change in interpretation is well-supported by how the Medicare 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 Section 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 healthcare for underserved communities who face the most discrimination and barriers, as many Medicare providers serve people with other forms of insurance.

For example, some organizations that provide medical equipment for patients and are covered by Medicare require that patients bring their own interpreters when consulting with staff. This leads to the problems mentioned above regarding having family and friends interpret.

One ATA member reported witnessing alleged discrimination against LEP claimants by insurance company agents. There are solutions for when certain services aren't covered by insurance, but customer service agents often avoid explaining them to LEP patients unless a third party, like an interpreter, is present because they know interpreters are familiar with the appeals process and how easily patients can ask insurance companies to, for example, override a non-formulary medication and cover it for certain patients through the exceptions and appeals process.

Finally, interpreters are impartial in an interpreting setting. This avoids conflicts of interest that could occur when an employer brings a patient to the hospital, for example, and offers to interpret for the patient.

Section 1557 coordinator

ATA supports the proposal that covered entities have a designated Section 1557 coordinator. OCR requested comments on whether this provision should apply to entities with fewer than 15 employees. ATA believes it is important that all covered entities have a designated person to ensure compliance with the law and these regulations. All too frequently, small to mid-size medical facilities/practices are not even aware that language access laws exist, let alone apply them. As a result, LEP patients are often told to bring a family member or a "bilingual" employee, whose job tasks are unrelated to medicine, to act as an interpreter.

Policies and procedures

ATA supports the provision related to implementing designated policies and procedures. Developing policies and procedures, and then requiring relevant staff to receive training, will ensure that covered entities are better able to meet the requirements of Section 1557.

ATA is unclear, however, whether the required policies and procedures include advance planning to identify what services might be required. ATA suggests that OCR either clarify this or specifically require covered entities to develop a language access plan. For example, the 2022 Proposed Rule discusses the need for “language access procedures,” which seems to be more of the “nuts-and-bolts” of how to schedule an interpreter, how to identify whether an individual is an LEP, etc. But there is no requirement that a covered entity consider in advance the types of language services it may need. That is, without gathering data about the LEP population in its service area, the entity may not be able to develop effective policies and procedures. The same is true for the section related to “effective communication procedures.”

HHS has long recognized the benefit of creating a language access plan. [HHS’ 2003 LEP Guidance](#) included elements of an effective language access plan. And as noted in the 2016 Section 1557 NPRM’s preamble, many organizations already develop such plans based on the model described in HHS LEP Guidance. Doing so ensures that covered entities understand:

- The scope of the populations they serve;
- The prevalence of specific language groups in their service areas;
- How often the covered entity serves those language groups;
- The nature and importance of the communications provided;
- The cost and resources available.

Depending on an entity’s size and scope, advance planning need not be exhaustive but is important to balance meaningful access with the obligations of the entity. The size and scope of the plan may vary depending on whether the covered entity is a small provider or a larger entity. OMH has also developed a [reference guide](#) for developing language access plans. Further, OCR can better monitor the compliance of entities that have a language access plan.

Specifically, a number of aspects of a language access plan mentioned in [HHS’ 2003 LEP Guidance](#) but not in the 2022 Proposed Rule include how to:

- Respond to LEP callers, including accurate determination of the language used by LEP callers;
- Respond to written communications from LEP persons;
- Respond to LEP individuals who have in-person contact with recipient staff, including accurate determination of the language used by LEP patients; and
- Ensure competency of interpreters and translation services.

ATA recommends that the accurate determination of the language used by LEP patients be included as an element of language access plans, as the rapid growth of Indigenous immigrant populations from Central and South America poses a specific challenge in the provision of language access. ATA has extensive, albeit anecdotal, evidence that healthcare providers mistakenly assign Spanish as the

patient's language based on their country of origin, when in many cases, the Indigenous patient does not speak Spanish at all.

In some cases, it can even be a challenge for providers to determine the language spoken by a patient. In one case, a Hindi interpreter appeared to interpret for a Gujarati-speaking patient. Though both Hindi and Gujarati are spoken in India, they are not mutually intelligible. Indigenous patients in the United States are often assumed to speak Spanish, but when a Spanish interpreter shows up, they are not capable of conveying information correctly during the encounter.

Furthermore, patients might need interpreting assistance in some settings and not in others. Their ability to schedule an appointment in English, for example, does not mean that they are able to have a high-level discussion with a hearing specialist about their child's hearing loss issues or with their oncologist about their recent surgery to remove cancer.

ATA would also recommend a requirement to develop policies and procedures to assess the competency of bilingual/multilingual staff. These could be language proficiency assessments or other methods of ensuring that bilingual/multilingual staff are indeed qualified to provide services directly in a non-English language.

Additionally, there are existing voluntary consensus standards, both national and international, for the quality of organizations providing language access, including [ASTM F3130-18](#), "Standard Practice for Language Services Companies," [ASTM F2575-14](#), "Standard Guide for Quality Assurance in Translation," [ASTM F2089-15](#), "Standard Practice for Language Interpreting," [ISO 21998:2020](#), "Interpreting services — Healthcare interpreting — Requirements and recommendations," and [ISO 17100:2015](#), "Translation services — Requirements for translation services."

Further, the provision on policies and procedures does not mention an expectation for ongoing evaluation or updating. As OCR notes in the [2003 LEP Guidance](#), "effective plans set clear goals and establish management accountability." ATA believes both goals and accountability are essential to ensuring effective implementation of Section 1557.

ATA recommends OCR either modify § 92.8 to clarify that additional steps to develop a language access plan (or a broader communication access plan that would include services for people with disabilities) are necessary before developing relevant policies and procedures. In the alternative, OCR could add a new provision requiring the development of a communication and accessibility plan prior to the development of policies and procedures.

Consider the recent Martha's Vineyard situation, where high school Spanish students were pressed to interpret for the migrants sent to the island by Governor DeSantis. Having an actionable language access plan would have allowed for professional interpreters to come to the assistance of the confused migrants and the community that was scrambling to help them.

Training

ATA supports the provision requiring training of relevant employees on the civil rights policies and procedures required by the proposed rule and recommends that the definition in the preamble be included in the regulation itself, either here or in the Definitions section. Not only must individuals in positions with "public contact" understand civil rights policies and procedures, but so should those who make decisions about these policies and procedures.

OCR should also require entities to develop training that encourages the best approaches to meeting the needs of LEP patients. For example, the provision should require training on how to best work with interpreters, particularly the type of interpreting the covered entity uses (e.g., in-person, over-the-phone, video remote). As noted by the American Medical Association's [Commission to End Health Care Disparities](#):

All employees should receive training so that they understand when an interpreter should be used, how interpreter services can be accessed, what the language services options are (e.g., in-person, telephone, video, translation services) and documentation requirements for quality, utilization, billing, and internal reporting purposes.

Such training not only ensures meaningful language access for LEP patients, but also helps protect the covered entity from potentially crippling civil rights litigation.

Notice of nondiscrimination

ATA strongly supports the requirements related to a notice of nondiscrimination. When this provision was removed in prior rulemaking, many individuals never received information about their rights, did not know how to access interpreters, auxiliary aids, and services, and did not know how to file a complaint or a grievance.

In addition to the current requirements, ATA also recommends requiring that covered entities that refuse to provide certain services due to sincerely held religious beliefs state that services are not covered in their notice of nondiscrimination. The notice should also be translated into other languages and the list of refused services provided.

Notice of availability of language assistance services

ATA strongly supports this provision and the requirements for when this notice must be made available. We also recommend that if a covered entity operates across multiple states, that the covered entity has to provide the notice in not merely the top 15 languages in the aggregate (that is, across all the states) but rather a total of the top 15 languages in each state. We also recommend that OCR require covered entities to require the notice in large print, at least 18-point font, as well as the top 15 languages. This will assist individuals with vision impairments in understanding the importance of the notice. As OCR has previously done, ATA also suggests that OCR develop and provide covered entities with model notices and translated information in the relevant languages that will be needed across the country.

ATA recommends that OCR specify that this notice must be provided at the beginning or on the first page of any document. Unfortunately, many documents in which this notice will be required can be lengthy. We do not believe an LEP person would look through multiple pages of a document in English if the notice is only at the end. Given the importance of this notice, we believe it should be the first page that everyone sees. This will benefit LEP individuals who will see information in their language and also individuals with disabilities who will require information in large print as well.

ATA also suggests that OCR develop and provide covered entities with model notices and translated information in the relevant languages that will be needed across the country. These notices should be specific to the type of publication in which they appear. For example, a notice for a consent form would likely be different from that for a public health emergency versus a notice about one's rights or benefits.

For languages that are not codified, such as the many Indigenous languages of Mexico and Central America, the availability of language services could include image-based or video communications. See [CIELO's videos](#) informing the Indigenous public about COVID precautions in 2020.

Meaningful access for LEP individuals

ATA supports the provisions related to meaningful access, including the requirements related to machine translation. Regarding the section on “evaluation of compliance,” we raise similar concerns to the ones above related to the lack of a requirement to develop a language access plan. The proposed rule does not seem to require covered entities to gather information about the needs of LEP individuals prior to developing policies and procedures. We believe doing so is important.

ATA also supports the clarification in the 2022 Proposed Rule relating to the restricted use of certain persons to interpret or facilitate communication. We support the addition of the expectation that in emergency situations, the reliance on an accompanying adult or minor should be “a temporary measure.” Reliance on accompanying adults and minors as unqualified interpreters has resulted in [well-documented cases](#) of life-altering decisions and medical malpractice lawsuits.

ATA appreciates the restoration of requirements related to video interpreting for LEP individuals, as many covered entities use video remote interpreting not only for Deaf or Hard of Hearing patients but also for LEP patients. The quality of interpreting handled remotely by video should be the same for all individuals who use it. For a spoken-language interpreter to perform their job effectively, a clear picture of all parties, along with crisp audio, are essential, as the interpreter cannot interpret what they don't hear.

ATA also recommends that OCR add a requirement that a “companion” of an LEP individual who needs language services must also be provided meaningful access, including access to qualified interpreters and translated materials. Just as the 2022 Proposed Rule requires covered entities to take appropriate steps to ensure effective communication for companions of individuals with disabilities, we recommend that the same be afforded to LEP individuals, particularly LEP parents/guardians of English-speaking minors/disabled adults and also family members, friends, or associates of LEP individuals who are appropriate persons with whom a covered entity should communicate. This could include individuals who participate in decision-making with the LEP individual or need to understand the information for caregiving and other related reasons.

There have been situations where a minor child receiving mental health services accompanied by their LEP parent has had to interpret for their parent due to the lack of a professional interpreter. It goes without saying how daunting such a circumstance is for both the child and the parent. Consider this scenario through the additional lens of cultural differences between the LEP parent and their child, as well as the LEP parent and the healthcare system they have brought their child to for help.

Telehealth services

ATA supports the inclusion of the provision on telehealth and the recognition of it as a tool to improve access for patients who, for various reasons, are unable or prefer to receive services in person. Telehealth has not been equitable for [LEP patients](#) and people with disabilities. Many telehealth service platforms have yet to be made fully accessible to [people with disabilities](#) or people with limited English proficiency.

As a basic step, OCR should require telehealth platforms to be able to include a third party such as an interpreter or use of auxiliary aids and services. Second, all of the 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 LEP patients and patients with 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 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 healthcare experience.

ATA also suggests 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.

Telehealth wasn’t designed for non-English speakers, but LEP patients have been affected by developments in telehealth. Our members have reported difficulties encountered by LEP individuals when COVID-19 test results were sent only through the telehealth system because the app they needed to use had not been translated and localized. Even if letters and messages are translated, patients may not be able to navigate to them in the app.

Clinical algorithms

The role of algorithms and other forms of automated decision-making systems (ADS) have long been recognized as a source of bias, discrimination, and wrongful denial of necessary care. When assessment tools are used with limited English proficient patients, additional errors may occur, particularly if qualified interpreters are not utilized to ensure the information needed in the tools is accurate and comprehensive. We request that OCR broaden the Proposed Rule to include any form of automated decision-making system because of the prevalence of automated decision-making systems used by covered entities.

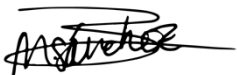
Enforcement mechanisms

ATA supports strong enforcement of Section 1557 and welcomes OCR’s recognition that the law protects people who experience intersectional discrimination. This can include individuals who have limited English proficiency and who also face discrimination due to their race/ethnicity, age, sex, and/or disability. We support clear, accessible procedures for filing, investigating, and remediating discrimination complaints.

Conclusion

Thank you for the opportunity to comment on this important issue. Please contact me with any questions you may have.

Sincerely,



Madalena Sánchez Zampaulo
President, American Translators Association