U.S. Department of Health and Human Services
Office for Civil Rights
Hubert H. Humphrey Building, Room 509F
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RE: 1557 NPRM (RIN 0945-AA17)

The Vermont Medical Society (VMS) is the largest physician membership organization in Vermont, representing approximately 2400 physicians, physician assistants and medical students across specialties and geographic locations. VMS is a 501(c)(6) nonprofit organization founded in 1784, dedicated to protecting the health of all Vermonters and improving the environment in which Vermont physicians and physician assistants practice medicine. Given the size of our state and medical practices, we submit these comments with a particular lens towards the impact on small medical practices.

The Vermont Medical Society fully shares the philosophy and supports the reasoning behind the Section 1557 rule. VMS agrees that members of groups that have historically faced discrimination and structural disadvantages in the United States experience disproportionately poor health status; further that racial and ethnic background, age, sex, gender, disability and LEP status leads to obstacles to health and accessing health care.

VMS supports Section 1557's strong statutory protections from discrimination in certain health programs and activities and supports finalizing the proposals in the rule to codify protections against discrimination on the basis of sex as including discrimination on the basis of sexual orientation and gender identity - including intersex traits; and pregnancy or related conditions including pregnancy termination.

However, VMS does have concern with a number of the new and/or reinstated administrative requirements contained in the rule and believes that the administrative burden on practices of several of these requirements will outweigh the benefits to patients. Our concerns are elaborated below:

Effective Date (§ 92.1)

HHS proposes the effective date of the Section 1557 implementing regulations to be 60 days after the publication of a final rule. Given the extent of new or expanded administrative requirements contained in the rule – addressed further below – such as drafting new/updated policies and procedures, staff training, and notice to patients, it is unrealistic to expect that

medical practices can understand and implement the changes within the proposed 60 days. This is especially true for the practices that would be impacted by the new proposed interpretation that Medicare Part B is federal financial assistance for the purpose of coverage under the federal civil rights statutes – and requiring compliance from practices that have not been covered entities in the past.

Practices are overburdened, dealing with workforce shortages and increased patient demands and health care needs in light of the COVID-19 pandemic and other emerging infectious diseases. Practices do not respond to administrative requirements in isolation. Other federal rules that practices are working to understand, interpret and implement at this time include, but are not limited to, recent expansions to Information Blocking (https://www.healthit.gov/buzz-blog/information-blocking/say-hi-to-ehi) and the No Surprises Act (https://www.cms.gov/nosurprises).

HHS' own Office of the U.S. Surgeon General issued an Advisory on Healthcare Worker Burnout earlier this year, calling on governmental entities to "reduce administrative burdens contributing to health worker burnout" and to "Partner with health care delivery organizations, professional associations, and other stakeholders to reduce documentation burden by 75% by 2025." (See https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf, page 34).

For the above reasons, VMS strongly urges that more than 60 days be given to come into compliance with the new administrative requirements – at least 180 days – with additional time such as 365 days being granted to practices that have not been subject to these requirements in the past. HHS already proposes the effective date of the training requirement be one year after the regulations are finalized and supports that timeframe.

Designation and Responsibilities of a Section 1557 Coordinator (§ 92.7)

The rule proposes that covered entities with 15 or more employees designate at least one employee to serve as a Section 1557 coordinator. VMS appreciates HHS's request for information regarding how the Department can support Section 1557 Coordinators. **VMS strongly supports the suggestion of providing training, as well as easy to understand summaries of the rule, outlines and checklists of the administrative requirements for covered entities, and requirements for the coordinator role, so that designated coordinators understand their duties and the protections afforded by Section 1557.** VMS supports the current proposal that this requirement only apply to practices with more than 15 staff as larger practices have more of an ability to task a specific staff member with oversight responsibilities.

Policies and Procedures (§ 92.8)

The rule would require covered entities to adopt and implement a nondiscrimination policy, grievance procedures and record retention requirements (for covered entities employing 15 or more persons), language access procedures, auxiliary aids and services procedures, and procedures for reasonable modifications for individuals with disabilities. The rule states that OCR is committed to supporting covered entities as they develop policies and procedures and is planning to provide sample documents on the Department's website. **VMS strongly urges OCR to develop and provide sample policy and procedure documents. Compliance will**

otherwise be very difficult and burdensome for small practices. Sample documents must be provided well in advance of compliance deadlines to give practices time to appropriately adapt samples to their practice needs and implement any changes in procedure. As stated above, more than 60 days from the date of a final rule will be needed for small practices to come into compliance.

HHS proposes that covered entities be required to retain records related to grievances filed with it that allege discrimination for a minimum of three years. First, it may be difficult for a practice to easily categorize the allegation of a complaint filed by a patient – often patient complaints are generalized regarding dissatisfaction with a clinical outcome or clinician or staff behavior and does not specify the basis of the allegation, such as discrimination. So, it may be difficult for a practice to determine if a complaint triggers the record retention requirement. Second, as detailed above, practices are overburdened with paperwork and documentation requirements. **For these reasons, VMS urges that record retention be stated as a recommended best practice but not an administrative requirement of the rule.** VMS also supports the requirement only being triggered for covered entities with more than 15 staff.

Training (§ 92.9)

HHS proposes that covered entities must train relevant employees (as further defined) on their Section 1557 Policies and Procedures required by section 92.8. Training will be required no later than one (1) year after the effective date of the Final Rule and when material changes are made to the covered entity's Section 1557 Policies and Procedures.

VMS supports giving covered entities one year from the effective date of the Final Rule to complete trainings. VMS also strongly recommends that OCR provide additional sample training materials or examples of how to run such trainings (such as walking through the organization's policies and procedures).

Notice of Nondiscrimination (§ 92.10)

HHS proposes to require that covered entities provide a notice of nondiscrimination on an annual basis and upon request; also that the notice be placed at a conspicuous location on the covered entity's website and in clear and prominent physical locations.

VMS appreciates that the content of the notice is clearly spelled out within the rule and asks that OCR provide a sample notice on its website for covered entities to use. VMS also supports posting the notice in a prominent physical location and on entities' websites. VMS strongly supports not re-implementing the requirement from the 2016 Rule that the notice to be provided in "significant communications." VMS does support the notice being provided to new patients, but does not support the notice being provided on an annual basis. Not all patients have contact with a covered entity on an annual basis, making this an arbitrary time frame to select. Further, not only are practices overwhelmed by administrative and paperwork requirements, but patients are overwhelmed with large stacks of paper at appointments, leading some polls to find that this even drives patients away from appointments (see https://www.fiercehealthcare.com/healthcare/paperwork-overload-may-drive-patients-away-from-providers). **For both effectiveness of reaching patients and to advance administrative**

simplification, VMS requests that the notice be distributed on the same basis as the HIPAA Notice of Privacy Practices: once to new patients, and then available on request, posted in a prominent physical location, on practice websites, and made available if changes are made to the document (see 42 CFR § 164.520).

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (§ 92.11)

HHS proposes that covered entities must provide notice of the availability of language assistance services and auxiliary aids and services in English and at least the 15 most common languages spoken by LEP individuals of the relevant state or states. This notice would have to be provided: on an annual basis, on a website, in clear and prominent physical locations, and, on an ongoing basis on a list of 10 categories of documents such as HIPAA Notice of Privacy Practices, intake forms, notifications of benefits, consent forms and compliant forms. OCR states in the proposed rule that it will provide a sample notice for covered entities to use, as well as identify the 15 most common non-English languages spoken by LEP individuals for each state and territory.

VMS supports OCR creating a sample notice and notifying covered entities of the 15 most common language spoken for each state. This information is surprisingly difficult to determine. For example, in trying to identify the top 15 language spoken in Vermont, the federal resource https://www.lep.gov/maps relies on data from 2015 or refers entities to a 13 page guide of how to download more recent regional data available from Census.gov (see https://www.lep.gov/sites/lep/files/media/document/2021-05/DemographicDataTIPS_042021.pdf). Asking each covered entity in a region to repeat this research is administratively burdensome and will lead to inconsistent or incomplete data.

VMS strongly opposes the framework of requiring this notice to be provided on an annual basis and on the 10 categories of documents listed in § 92.11 (c)(5). In addition to the concerns listed in the section above regarding an annual notice of nondiscrimination, requiring the notice on the list of 10 documents could lead to a patient receiving this information multiple times for one encounter – burdensome to the practice and duplicative for the patient. For example, if the patient joins the practice as a new patient with typical intake paperwork and has an appointment with a copay, that could lead to at least 4 notifications (with the notice of privacy practices, with intake paperwork, with a notice of copay, and in the patient handbook.) These may all be required before the practice is able to document the patient's primary language under § 92.1 (d)(2). The opt out option also requires providing the option to opt out on an annual basis and 5 steps for the practice to complete - leading to it being more burdensome to the practice to document these steps than simply continuing to provide the patient the notices, even if the patient would prefer not to receive them. Further, segmenting patient paperwork between those who have opted out, those who have a primary language documented, and those who have not, would be nearly impossible for a practice to implement – leading to notice continuing to be provided in all of the required instances to all patients.

VMS strongly urges OCR to combine the notice of nondiscrimination with the notice of availability of language services and have them both distributed on the same frequency as the HIPAA Notice of Private Practices found at 42 CFR § 164.520. This frequency would lead to a reasonable balance between informing patients that such services are available without

being overly burdensome or duplicative. OCR has found this balance appropriate in notifying patients regarding Privacy Practices, which apply to all patients of a practice, where the balance proposed it this rule would require much more frequent notification to reach a very small percent of patients in Vermont (latest estimates put the LEP population of Vermont at under 2%).

OCR also asked for feedback regarding only requiring translated Notice of Availability if there are at least 200 LEP speakers for a particular language in the relevant state or states. VMS would support this requirement as according to the 2015 US census data, there are only 8 languages in Vermont spoken by more than 200 LEP individuals, with the remaining being spoken by fewer than 200 individuals. This would reduce the length of notices practices are required to provide – although adopting this abbreviated requirement would also be less necessary if the frequency of providing notices was reduced, as discussed above.

Thank you for accepting these comments on behalf of the Vermont Medical Society. We appreciate and share your commitment to protecting patients against discrimination and ask for the Final Rule to reduce the paperwork burden on medical practices and patients while still informing patients of these important rights.

Sincerely,

Jessa Barnard
Executive Director