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National Advocates for Asian American, Native Hawaiian & Pacific Islander Health

February 15, 2011

Health Resources and Services Administration
U.S. Department of Health and Human Services
Office of Shortage Designation, Bureau of Health
Attention: Nicole Patterson
Room 9A-18, Parklawn Building
5600 Fishers Lane,
Rockville, MD 20857

Re: *Comments on Meeting of the Negotiated Rulemaking Committee on Designation of Medically Underserved Populations and Health Professional Shortage Areas*

Dear Ms. Patterson:

The Asian & Pacific Islander American Health Forum (APIAHF) thanks the Health Resources and Services Administration (HRSA) and the Negotiated Rulemaking Committee on the Designation of Medically Underserved Populations and Health Professional Shortage Areas (NRMC-MUA) for the opportunity to comment on the committee's task of developing comprehensive methodology and criteria for the Designation of Medically Underserved Populations and Primary Care Health Professional Shortage Areas. Asian Americans, Native Hawaiians and Pacific Islanders (AA and NHPI) face numerous barriers to care, including linguistic and cultural, and suffer disproportionately high rates of cervical cancer, stomach cancer, hepatitis B, mental health issues, and many other serious health impairments.

The development of methodology and criteria for designating medically underserved populations and health professional shortage areas directly impacts access to health care for historically underserved and disadvantaged groups, and should take into account many of the barriers faced by these communities, such as the impact of limited English proficiency, immigration status, lack of culturally appropriate care and lack of health insurance.

For these reasons, we strongly support the development of a comprehensive methodology and criteria for the Designation of Medically Underserved Populations and Primary Care Health Professional Shortage Areas through the negotiated rulemaking process and public input. In addition, we urge HRSA and NRMC-MUA to consider the following when developing methodology and criteria:

<u>Consider Linguistic and Cultural Barriers as Health Status Indicators</u>

Asian Americans, Native Hawaiians and Pacific Islanders speak more than 100 different languages. Data from the Census Bureau's American Community Survey reveal that more than 8 million people in the United States speak Asian and Pacific Island languages at home and more than 4 million of them are considered "limited English proficient," meaning they speak English less than "very well" or not at all.[i]

Numerous federal policies and guidelines recognize the role that linguistic and cultural barriers play in access to health care. Title VI of the Civil Rights Act of 1964 prohibits discrimination in federal programs on the basis of race, color or national origin, and has lead to the development of language access guidance in

many federal departments and agencies, including HHS. In addition, the Department of Health and Human Services (HHS) developed the Cultural and Linguistic Appropriate Services (CLAS) standards in health care, which are used by national accrediting agencies such as the Joint Commission and NCQA. Section 1557 of the Patient Protection and Affordable Care Act (PPACA) also reinforced Title VI protections against any health care program or entity receiving federal financial assistance, credits, subsidies or contracts of insurance.

Language barriers are widely known to reduce rates in enrollment and lower the quality and effectiveness of prevention, treatment and patient education programs. Poor communication between providers and patients can also lead to medical errors that are dangerous to patients and cost the U.S. health care system more than $69 billion every year. As such, many hospitals, health plans, and private physician offices have voluntarily adopted language access practices in an effort to increase patient safety and improve quality.[ii] In addition, due to these communication and cultural barriers, providers serving LEP patients generally devote more time providing care.

For these reasons, we urge the NRMC-MUA to consider linguistic and cultural barriers as an indicator in establishing a comprehensive methodology and criteria for the Designation of Medically Underserved Populations. Linguistic and cultural barriers should be measured by direct indicators, rather than indices, that are easily understood by the public such as race, ethnicity, immigration status and linguistic isolation.

<u>Include Uninsured Status as a Health Indicator and Variable</u>

High rates of uninsurance (over one in six Asian Americans and one in four Native Hawaiian and Pacific Islanders) compound many of the obstacles low income and minority communities face in achieving good health. For instance, many Asian American women work in small businesses and industries where health insurance is unaffordable. Disaggregation of data shows that Korean Americans experience the highest rates of uninsurance of any racial or ethnic group. Lack of health insurance is accepted as a significant barrier impeding access to health care and maintaining good health. Therefore, we request the NRMC-MUA consider uninsured status as a health indicator and variable when establishing methodology and criteria for the designation.

<u>Recognize Local and Population-Specific Health Conditions</u>

Minority and LEP populations, such as AA and NHPIs, experience a number of health disparities relative to the white population. For example, Asian American and Pacific Islander communities are overwhelming immigrant, with over 60 percent of Asian Americans and 30 percent of Pacific Islanders living in the U.S. are foreign-born, representing the full spectrum of immigration status categories. Immigration status is known to interfere with the types of health care accessible to persons and correlated with lack of insurance and other unmet health needs.

The revised MUP and HRSA designation methodology should be more appropriate for disenfranchised populations and incorporate flexibility to take into account the unique health factors and social vulnerabilities affecting these populations. The

revised methodology should allow communities to choose from a menu of health status indicators, based on national priorities, such as those outlined in Healthy People 2020.

Ensure that any Proposed Designation Method is Transparent, Easily Understandable, and uses Easily Available Data

The PPACA states that "the degree of ease or difficulty that will face potential applicants for such designations in securing the necessary data" should be taken into account. Communities that are truly medically underserved must be able to demonstrate their status without significant burdens. Any method must have a scientific-basis, but be easily understandable and use easily available data to avoid already strapped communities from being forced to rely heavily on expensive consultants and "experts" to demonstrate their underserved status.

In conclusion, APIAHF appreciates the opportunity to comment on the development of methodology and criteria for the Designation of Medically Underserved Populations and Primary Care Health Professional Shortage Areas. Please contact Priscilla Huang, Associate Policy Director, at phuang@apiahf.org with any questions or for additional information.

Respectfully,

Kathy Lim Ko
President & CEO
Asian & Pacific Islander American Health Forum

[i] "Language Use in the United States: 2007," U.S. Census Bureau, American Community Survey Reports, April 2010. Available at http://www.census.gov/prod/2010pubs/acs-12.pdf.
[ii] *See* The Joint Commission, "Hospitals, Language, and Culture: A Snapshot of the Nation," 2007. Available at http://www.jointcommission.org/assets/1/6/hlc_paper.pdf. *See also* Mara Youdelman and Jan Perkins, National Health Law Program, "Providing Language Services in Small Health Care Provider Settings: Examples From the Field," April 2005. Available at http://www.commonwealthfund.org/usr_doc/810_Youdelman_providing_language_services.pdf.