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

October 03, 2022

Melanie Fontes Rainer  
Office for Civil Rights  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 509F  
200 Independence Avenue SW  
Washington, DC 20201  
*Submitted electronically via www.regulations.gov*

**RE: Nondiscrimination in Health Programs and Activities [Docket ID HHS-OS-2022-0012-0001]**

Dear Director Fontes Rainer:

Thank you for the opportunity to respond to the Department of Health and Human Services Office for Civil Rights (HHS-OCR) Notice of Proposed Rulemaking, *Nondiscrimination in Health Programs and Activities* [Docket ID HHS-OS-2022-0012-0001]. The Asian & Pacific Islander American Health Forum (APIAHF) and the undersigned national, state, and local organizations commend HHS-OCR for restoring and clarifying critical healthcare protections in Section 1557 of the Affordable Care Act (Section 1557). While we continue to urge congress to make healthcare more accessible and affordable for all, we are encouraged to see that the proposed rule moves us closer towards health equity. If finalized with our recommendations, the rule would provide clearer guidelines that ensures the health and protection of our diverse communities.

The organizations represented work to advance the health and well-being of over 25 million Asian Americans, Native Hawaiians and Pacific Islanders (AA and NHPI) across the U.S. and territories. We aim to improve access to and the quality of care for communities who are predominantly immigrant, many of whom are limited English proficient (LEP) and may be new to the U.S. healthcare system.

We draw upon our extensive experience and the relationships fostered to understand the needs and barriers faced by AA and NHPI communities across the U.S. and territories, and the impact that changes outlined in the proposed rule would have on those individuals and communities. Per the request of the NPRM, this letter will address provisions related to:

1. Language access;
2. Discrimination on the basis of sex;
3. Data collection; and
4. Medicare Part B.

## 1. LANGUAGE ACCESS

We welcome the language access protections restored to its original intent and clarified in the proposed rule. With more than 1 in 3 AAs and NHPs who are LEP, language access is critical to equitable access to quality healthcare in our communities. Title VI of the 1964 Civil Rights Act, EO 13166, and Section 1557 are vital protections for individuals with LEP to navigate the healthcare system, communicate with their doctors, and ensure they receive appropriate and quality care. The dismantling of language access protections in the 2020 Final Rule posed a threat to the health and safety of individuals with LEP as seen in the ongoing pandemic.

The COVID-19 pandemic, coupled with the Section 1557 language access rollbacks in the 2020 Final Rule had detrimental consequences for individuals with LEP. In a survey APIAHF conducted of 45 community-based organizations, 89% reported needing in-language and culturally appropriate resources about COVID-19.<sup>1</sup> In addition to not receiving timely information on COVID-19, serious concerns of language barriers leading to rationing of care arose.<sup>2</sup>

These anecdotes from the COVID-19 pandemic reflect the broader experiences of individuals with LEP accessing healthcare and other government services. While COVID-19 did exasperate disparities for individuals with LEP, barriers to language accessible and culturally responsive healthcare has long been a social determinant of health for AA and NHPI communities with LEP. Often, patients with LEP are left with sub-par care when compared to their English proficient counterparts due to convenience of the provider rather than the interest of the patient.<sup>3</sup> For AA and NHPI communities, these language barriers create challenges to some of the most mundane aspects of accessing healthcare, like making appointments, communicating with healthcare professional, and being informed about an illness, resulting in poorer health outcomes.<sup>4</sup>

As such, the comments and recommendations below reflect upon improving the experiences of AA and NHPI individuals with LEP in accessing healthcare.

### a. Definitions (§ 92.4) – Qualified Interpreters, Qualified Readers, Qualified Translators

We support the definition of qualified interpreters, qualified readers, and qualified translator in the context of language services for individuals with LEP. These new definitions will bring more clarity to quality of interpreter, readers, and translators that are required to equitably serve individuals with LEP. Similarly, we support the implementation of these definition for individuals with disabilities, such that the definitions are consistent and adhere to same principles as much as possible to prevent confusion and compromise in quality of service.

The principles set in these definitions will help remedy the use of unqualified or ad hoc interpreters, like family members, friends or untrained employees, who run a high risk of misinterpreting and creating greater harm to the LEP patient. According to HHS Agency for Healthcare Research and Quality report, LEP patients often experience longer hospital stays when there is a lack of qualified interpreters, resulting in greater risks of

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<sup>1</sup> “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/>.

<sup>2</sup> Joshua Kaplan, “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>.

<sup>3</sup> Alexander R. Green, MD, MPH and Chijioke Nze, “Language-Based Inequity in Health Care: Who Is the ‘Poor Historian’?,” AMA Journal of Ethics (2017). Available at: <https://journalofethics.ama-assn.org/article/language-based-inequity-health-care-who-poor-historian/2017-03>.

<sup>4</sup> Wooksoo Kim et al., *Barriers to Healthcare Among Asian Americans*, 25 Soc. Work in Pub. Health 286, 289 (2010). Available at: <https://www.tandfonline.com/doi/pdf/10.1080/19371910903240704?needAccess=true>.

negative health outcomes.<sup>5</sup> Further, using children, family members or friends as interpreters may not only risk wrong information being conveyed, but the LEP patient may also feel uncomfortable sharing sensitive health information in the presence of a close family member or friend, in addition to conflicting with privacy ethics.

*Recommendation*

- We suggest that the definition of qualified interpreters for individuals with disabilities should also include language from the definition of qualified interpreters for individuals with LEP that states that a qualified interpreter is an interpreter who:
  - (1) *Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language;*
  - (2) *Is able to interpret effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary or terms without changes, omissions, or additions and while preserving the tone, sentiment, and emotional level of the original oral statement; and*
  - (3) *Adheres to generally accepted interpreter ethics principles, including client confidentiality.*

**b. Designation and responsibilities of a Section 1557 Coordinator (§ 92.7)**

We support the designation of a Section 1557 Coordinator at ***all covered entities***, including entities with fewer than 15 employees to ensure compliance with laws and regulations, and foster a deeper understanding and culture of providing equitable quality care to underserved communities. While the implementation of a Section 1557 Coordinator may naturally differ between smaller and larger covered entities, requiring that all covered entities designate a Section 1557 Coordinator will provide greater assurance that individuals will be able to access care and without fear of discrimination from the provider of their choosing, thus aligning with the true intent and principles of Section 1557.

*Recommendation*

- All covered entities, including entities with fewer than 15 employees, should designate a Section 1557 Coordinator to ensure compliance with laws and regulations. The implementation of the designation and should take into account the size of the covered entity, including the size of the staff and the population size serviced.

**c. Policy & Procedures (§ 92.8)**

We appreciate and support the proposal to require each covered entity adopt and implement policy and procedures on nondiscrimination, grievances, language access, auxiliary aids and services, and reasonable modifications for individuals with disabilities. Through this process, employees will be better equipped and prepared to serve the needs of the public and will have a point of reference when instances pertaining to Section 1557 arises.

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<sup>5</sup> U.S. Dept. of Health & Human Servs., *Agency for Healthcare Research & Quality, Executive Summary: Improving Patient Safety Systems for Patients with Limited English Proficiency* (Sept. 2020). Available at: <https://www.ahrq.gov/health-literacy/professional-training/lepguide/execsummary.html#what>.

However, it should be made clear that language access *procedures* should supplement, and not supplant language access *plans*. The “language access procedures” mentioned in the proposed section refers to procedures most likely found in an employee manual or handbook. For example, the proposed rule states:

*“language access procedures must include information detailing the contact information for the Section 1557 Coordinator (if applicable); how an employee identifies whether an individual is LEP; how an employee obtains the services of qualified interpreters and translators the covered entity uses to communicate with individuals with LEP; the names of any qualified bilingual or multilingual staff members...”*

This indicates that the language access procedure are steps for an employee to follow when coming into contact with an LEP individual. While this is valuable, a language access plan differs from these procedures. A language access plan considers and evaluates needs of a service area and population. The plan allows for providers to better understand the populations in a service area, the prevalence of specific language groups in the service area, the acute needs of particular language groups, and the scope of service needed that will meet standards of meaningful access. In a sense, the language access plan proceeds and informs the steps in the language access procedure.

*Recommendation*

- Prior to developing a language access procedure, covered entities should assess the population and language access needs in their service area through a language access plan. This will allow covered entities to create policies and procedures that identifies particular areas of need and the scope of services and resources made available that are best suited for the population they serve.

**d. Training (§ 92.9)**

We thoroughly support the requirement for covered entities to train employees on the policy and procedures set in § 92.8. It is essential for employees who come in direct contact with the public are knowledgeable about the policies and procedures to effectively serve individuals with LEP and individuals with disabilities as this is a critical point of contact that can play significant role in health outcomes.

However, the language proposed in § 92.9 must reflect the intent set in the preamble. The proposed language only states that “relevant employees” should be trained on civil rights policies and procedures without describing who these relevant employees are. Conversely, the preamble states that “relevant employees” include those “involved in client and patient interactions, as well as those involved with drafting, approving, and funding policies and procedures for compliance with this part.” Thus, we call for the description of relevant employees in the preamble to be included in the proposed language of § 92.9.

*Recommendation*

- The definition of “relevant employee” in § 92.9 should be clarified and include the description found in the preamble that states that a relevant employee include “those involved in client and patient interactions, as well as those involved with drafting, approving, and funding policies and procedures for compliance with this part.”

**e. Notice of Nondiscrimination (§ 92.10)**

We support the proposed requirement for covered entities to provide a notice of nondiscrimination, relating to their health programs and activities, to participants, beneficiaries, enrollees, and applicants of their health programs and activities, and to members of the public. It is critical that individuals with LEP and individuals with disabilities understand their right to meaningful access to care, including how to access qualified interpreters or appropriate auxiliary aids and services. Further discussion on notices is continued below.

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

We strongly support the requirement for covered entities to provide a notice that, at minimum, states that the covered entity provides language assistance services and appropriate auxiliary aids and services free of charge in its health programs and activities. The use of these notices, or “taglines,” is a cost-effective approach to ensure that individuals with LEP are aware of language access services in the absence of fully translated documents.

However, instead of requiring the availability of notices “in the 15 most common languages spoken by individuals with LEP of the relevant state or states,” we propose that notices are available in the top 15 languages spoken by individuals with LEP in a single *service area*, whether that area covers a state or states, county or city. Focusing on a single service area allows for greater flexibility, especially in the case for covered entities in large states like California where commonly spoken languages differ between regions of the state, or highly condensed cities like New York City whose population may differ from the rest of the state. This amendment also recognizes covered entities located on the border of two states; allowing a covered entity to focus on the language needs of a single service area eliminates the confusion of assessing and applying the top 15 languages of multiple states which, additionally, may not ultimately meet the needs of a covered entity’s serviced population.

We also appreciate the recognition of the importance of notices and taglines for “significant publications or significant communications” and the efforts to reduce confusion about what qualifies as “significant” by providing a list of instances where notices are required. We note, however, that this list may be only a portion of what covered entities, and federal and state agencies may already provide and/or require. As such, the section should include language that clarifies that the list of forms included in § 92.11(5) should be a minimum, and does not conflict with other requirements that expands on the list.

**Recommendation**

- § 92.11 should be amended such that notices of availability of language assistance services are provided in the top 15 languages spoken by LEP individual in a covered entity’s single service area. This amendment allows greater flexibility and is more appropriate to meet the language access needs of the service area population.
- The notice of availability of language assistance services and auxiliary aids and services must be provided, at minimum, for the list of forms indicated in § 92.11(5). Covered entities must comply with other state, local, or federal guidelines specific to the health program that may be beyond the requirements of § 92.11.

**g. Meaningful Access for Limited English Proficient Individuals (§ 92.201)**

*§ 92.201(a) General requirement*

We applaud and support the restoration of meaningful access for individuals with LEP to include “must take reasonable steps to provide meaningful access to *each* limited English proficient individual eligible to be served or likely to be directly affected by its health programs and activities.” The operative word “each” ensures that reasonable steps are taken to provide meaningful access to the specific and unique needs of individuals with LEP, rather than a generic aggregate group.

*§ 92.201(c)(3) Specific requirements for interpreter and translation services – Machine Translations*

We appreciate the inclusion and discussion of machine translation and acceptable uses of it. It is important that machine translations are reviewed by qualified human interpreters, especially in the context of complex documents and culturally appropriate language. We have, however, reservations on the use of machine translations that are not reviewed by qualified human interpreters. Although the use of machine translations is convenient, often cost effective, and is becoming more readily available, the risk of error in this technology is still high. Further, like in the case of what qualifies a “significant” communication in the section on Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (§ 92.11), confusion may occur on what event qualifies as “critical to the rights, benefits, or meaningful access of a limited English proficient individual, when accuracy is essential, or when the source documents or materials contain complex, nonliteral or technical language” to initiate review by a qualified human interpreter as described in § 92.201(c)(3). Both the errors that will likely occur with machine translations and the confusion that may arise on what type of document must be reviewed by qualified interpreters, can be easily resolved by having a qualified interpreter review all machine translated materials.

*§ 92.201(d) Evaluation of compliance*

We raise similar concerns to the “evaluation of compliance” section to the concerns on the lack of language access plans in § 92.8 (Policy and Procedures). We appreciate that OCR will evaluate the entity’s written language access procedures, but those procedures must be guided by a language plan that surveys the needs of the LEP population in the covered entity’s service area.

*§ 92.201(e) Restricted use of certain persons to interpret or facilitate communication*

Lastly, we support the restricted use of certain persons to interpret or facilitate communication, especially the use of children or minors, as interpreter for individuals with LEP with exception of temporary emergency situations or instances to obtain a qualified interpreter. Further, we emphasize that only qualified interpreters, qualified readers, and qualified translators are used to serve individuals with LEP in normal circumstances and appreciate the reinforcement that language assistance services are provided free of charge to individuals with LEP and with respect to their privacy. As mentioned in the sections above, access to a qualified interpreter plays an integral part in the health outcome of LEP patients. Further, emphasizing the use of qualified interpreters normalizes the practice, puts into practice the efficacy of the Notice of Nondiscrimination (§ 92.10) and Notice and Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (§ 92.11), and shifts the burden of ensuring language access services from the LEP individual to the covered entity, as it is a required health service.

*Recommendations*

- The evaluation of compliance in providing meaningful access to individuals with LEP must consider, in addition to a language access procedures, the implementation and evaluation of its language access plan.

- All machine generated translations should be verified by a qualified interpreter. While there have been many advances in technology over the years, machine generated translations, as noted in the preamble, is still riddled with errors. These errors, especially in the context of health, can be harmful to individuals with LEP and can be easily remedied by a review from a qualified interpreter.

## **2. DISCRIMINATION ON THE BASIS OF SEX**

AA & NHPI communities represent a diverse population of identities, all of which should not prevent access to healthcare. As such, we applaud HHS on making bold efforts to restore protections for many in our communities who have been historically discriminated against in accessing care, particularly LGBTQI+ individuals, women and individuals capable of becoming pregnant.

The unprecedented decision of *Dobbs v. Jackson Women’s Health Organization*, 597 U.S. (2022) upended decades of privacy, autonomy, and healthcare protections that generations of Americans have relied on. AA and NHPI women and individuals capable of becoming pregnant already faced challenges accessing health care, including reproductive care, prior to the *Dobbs* decision. Thus the end results of *Dobbs* only increases barriers to care and fuel bias that can only be alleviated by Section 1557.

AA and NHPI women and individuals face significant barriers in accessing sexual and reproductive healthcare, like contraception, fertility care, abortion, gender-affirming care, and maternity care. These barriers are caused by laws like the Hyde Amendment that restricts Medicaid funds, and discriminatory policies like sex-selective abortion legislation that results in denying AA and NHPI women and individuals access to abortion care under racist notions that AA and NHPI cultures prefer males over females.<sup>6</sup> AA and NHPI women are also subjugated to increased risk of criminalization for their pregnancy outcomes, like with fetal homicide laws that criminalize people experiencing miscarriages, as seen in the Bei Bei Shuai and Purvi Patel cases in Indiana.<sup>7</sup>

As such, the comments and recommendations below reflect upon improving the experiences of AA and NHPI LGBTQI+ individuals, women, and individuals capable of becoming pregnant in accessing healthcare.

### **a. Discrimination Prohibited (§ 92.101)**

We support proposed paragraph § 92.101 (a)(2) that clarifies discrimination on the basis of sex to include discrimination on the basis of sex stereotypes; sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; and gender identity.

It is of the utmost importance that our rules and laws are consistent with the Supreme Court of United States (SCOTUS) case law and precedent. SCOTUS held in *Price Waterhouse v. Hopkins* (1989) that discrimination on basis of sex can be established when the cause for discrimination is based on gender stereotypes; and recently in *Bostock v. Clayton County* (2021) that discrimination on the basis of sex includes discrimination on the basis of sexual orientation and gender identity. Together, these SCOTUS decisions gives ample guidance on the definition of “discrimination on the basis of sex” for lower courts and other government entities to follow.

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<sup>6</sup> National Asian Pacific American Women’s Forum et al, *Visibility, Voice, Vision: Asian American & Pacific Islander Reproductive Rights Agenda* (May 2021). Available at: <https://www.napawf.org/our-work/content/2021/5/27/visibility-voice-vision-asian-american-and-pacific-islander-reproductive-justice-agenda>.

<sup>7</sup> Id.

While the *Dobbs* decision eliminated the constitutional right to abortion, it does not allow for providers to discriminate against persons who have received an abortion or services for other pregnancy related conditions. Thus, as a point of further clarification, we urge that definition explicitly mention “termination of pregnancy” as a pregnancy related condition.

**Recommendation**

- The definition of discrimination on the basis of sex as proposed in § 92.101 (a)(2) should explicitly mention termination of pregnancy as a pregnancy related conditions as suggested:

*Discrimination on the basis of sex includes, but is not limited to, discrimination on the basis of sex stereotypes; sex characteristics, including intersex traits; pregnancy or related conditions, **including termination of pregnancy**; sexual orientation; and gender identity.*

**b. Equal program access on the basis of sex (§ 92.206)**

We applaud the restoration of protections for gender-affirming care and clarifying that covered entities may not refuse gender-affirming care to a patient based on a personal aversion. Additionally, “equal program access on the basis of sex” should also be made explicitly available to groups historically discriminated against on the basis of sex as defined under § 92.101(a)(2) of the proposed rule. Similar to the issues discussed in the above section, the *Dobbs* decision may cause individuals to be inappropriately denied care due to receiving abortion or inquiring about contraception or other conditions related to pregnancy. In order to strengthen the protections of the section, we urge the explicit inclusion of specific forms of discrimination related to pregnancy and related conditions, including termination of pregnancy.

**Recommendation**

- § 92.206 protections on equal program access on the basis of sex should explicitly include language on discrimination related to pregnancy and related conditions, such as termination of pregnancy, contraception, miscarriage management, fertility care, maternity care, and reproductive or sexual health care decisions or history.

**c. Prohibition on sex discrimination related to marital, parental or family status (§ 92.208)**

While we applaud the efforts in this section to include protections the specifically mentions “pregnancy or related conditions, including abortion,” we also recognize including this provision within this section title could cause bias and confusion for people experiencing discrimination based on obtaining or having obtained an abortion outside the marital, parental, or family context. We urge that this section on discrimination based on obtaining an abortion is included in the broader definition in § 92.101(a)(2).

**Recommendation**

- § 92.208 protections for “pregnancy or related conditions, including abortion” should be included in the definition of “discrimination on the basis of sex” in § 92.101(a)(2). Please see suggested amendment to the proposed rule above in the portion discussing § 92.101.



### 3. DATA COLLECTION

We applaud the Biden-Harrison Administration’s focus on equity as articulated in Executive Order 13985 (EO 18985), *On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*. In particular, EO 13985 established the White House Equitable Data Working Group recognizing that the “lack of data has cascading effects and impedes efforts to measure and advance equity.”

Health equity cannot be achieved without data equity, including data that is complete, accurate and disaggregated. The COVID-19 pandemic underscored the deficiency of the reporting of data for AA and NHPI communities in the U.S.<sup>8</sup> As late as April 2021, only about half of COVID-19 cases reported to the CDC included information on race or ethnicity.<sup>9</sup> Further examination of the reported data showed that states that reported on AA and NHPI racial and ethnic data did so in varying degrees or not at all. The product of this inaccurate data effectively erases the COVID-19 impact on AA and NHPI communities, despite COVID-19 becoming the third leading cause of death for the AA and NHPI population in 2020.<sup>10</sup> For NHPI communities in particular, the COVID-19 data disparities were so dire, that students, researchers and NHPI community organizers came together to create the NHPI COVID-19 Data Policy Lab to make data on NHPI populations more accessible and reflect a more accurate picture of the impact of COVID-19 in NHPI communities.<sup>11</sup>

Outside the context of COVID-19, detailed demographic data is not often collected, analyzed or reported for AA and NHPI Medicare beneficiaries, obscuring the experiences of this growing demographic. Not only is demographic data on AA and NHPI beneficiaries not regularly available, when the data is reported, it is likely inaccurate. A 2022 report by HHS Office of the Inspector General found that Medicare’s enrollment data on race and ethnicity is less accurate for certain groups, especially American Indian/Alaska Natives, Asian/Pacific Islanders, and Hispanics.<sup>12</sup>

Further, using only aggregated data for AA and NHPI communities often masks the disparities of underserved communities within the AA and NHPI umbrella. A report from Pew Research Center found that among all racial groups, the greatest socioeconomic gaps are among AA and NHPI communities.<sup>13</sup> Without disaggregated data, the disparities in health, income, education, and other socio-economic factors of certain AA and NHPI subgroups are silenced and drives false narratives such as the model minority myth, where AA and NHPI communities are seen as “healthy” by the general public.<sup>14</sup>

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<sup>8</sup> Stella Yi et al, *The Mutually Reinforcing Cycle of Poor Data Quality and Racialized Stereotypes That Shapes Asian American Health*, Health Affairs (February 2022). Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01417>

<sup>9</sup> “Demographic Trends of COVID-19 cases and deaths in the US reported to CDC,” Center for Disease Control and Prevention (Accessed April 7, 2021) available at: <https://covid.cdc.gov/covid-data-tracker/#demographics>.

<sup>10</sup> Centers for Disease Control and Prevention (2020). *National Vital Statistics System – Mortality data, Leading causes of death for Asian or Pacific Islander non-Hispanic population*. Retrieved from <https://www.cdc.gov/nchs/fastats/asian-health.htm>.

<sup>11</sup> Elaiza Torralba, *COVID-19 exposes how Native Hawaiians and Pacific Islanders face stark health care disparities*, UCLA Newsroom (Aug. 25, 2020). Available at: <https://newsroom.ucla.edu/stories/covid-19-stark-differences-NHPI>; See also: NHPI COVID-19 Data Policy Lab Dashboard. Available at: <https://healthpolicy.ucla.edu/health-profiles/Pages/NHPI-COVID-19-Dashboard.aspx>.

<sup>12</sup> *Data Brief: Inaccuracies in Medicare’s Race and Ethnicity Data Hinder the Ability to Assess Health Disparities*, June 2022. Available at : <https://oig.hhs.gov/oei/reports/OEI-02-21-00100.pdf>.

<sup>13</sup> Abby Budiman and Neal G. Ruiz, *Key facts about Asian Americans, a diverse and growing population*, Pew Research Center (April 2021). Available at: <https://www.pewresearch.org/fact-tank/2021/04/29/key-facts-about-asian-americans/>.

<sup>14</sup> Stella Yi et al, *The Mutually Reinforcing Cycle of Poor Data Quality and Racialized Stereotypes That Shapes Asian American Health* (February 2022). Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01417>.

Data equity and data disaggregation for AA and NHPI populations has significant implications because more accurate data can identify health and services gaps, and inform the equitable distribution of resources directed to and made available for communities. **Thus, we urge HHS to include provisions on improving data collection, analysis, and reporting into ACA Section 1557.**

#### **4. MEDICARE PART B**

We support the inclusion of Medicare Part B payments as federal financial assistance and Part B providers and suppliers as recipients under Section 1557, Title VI, Title IX, Section 504, and the Age Act. In 2050, nearly 7 percent of the U.S. population aged 65 and over is projected to be Asian while 0.3 percent is projected to be NHPI. In 2019, AA and NHPI individuals comprised approximately 4 percent of all Medicare enrollees, or over 2.3 million.<sup>15</sup> As such, the inclusion of Medicare Part B has significant impact for AA and NHPI elders and persons with disabilities.

Benefits from Medicare Part B were originally paid out to beneficiaries, who then paid health providers for services received. The payment scheme prevented Medicare Part B from being covered under Section 1557 because providers were not direct recipients of federal financial assistance. However, the payment scheme has changed to where providers are now receiving direct payments from CMS instead of the Medicare Part B beneficiaries, as in the case of other Medicare plans covered by Section 1557. These direct payments from CMS make Medicare Part B providers recipients of federal financial assistance, thus making the exclusion of Medicare Part B from Section 1557 protections moot. Further, bringing all Medicare providers under this rule will also 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.

#### **CONCLUSION**

We appreciate the opportunity to comment on the proposed rule. The restoration and clarification of the rules to the true intent of Section 1557 is an enormous feat by HHS-OCR that we are truly thankful for. We offer our comments and recommendations for your consideration and a reflection of the impact Section 1557 has on AA and NHPI communities and other underserved communities. Should you have questions or would like to request additional information, please contact [policy@APIAHF.org](mailto:policy@APIAHF.org).

Sincerely,

#### **National Organizations**

Asian & Pacific Islander American Health Forum (APIAHF)  
2020 Mom  
ACA Consumer Advocacy  
Asian & Pacific Islander Caucus for Public Health  
Asian Americans Advancing Justice - AAJC  
Asian Pacific American Labor Alliance, AFL-CIO  
Asian Pacific American Medical Student Association  
Community Catalyst

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<sup>15</sup> *Distribution of Medicare Beneficiaries by Race/Ethnicity*, Kaiser Family Foundation (2019). Available at: <https://www.kff.org/medicare/state-indicator/medicare-beneficiaries-by-raceethnicity/>.

Empowering Pacific Islander Communities  
Health Care Voices  
Hep B United  
Hepatitis B Foundation  
Japanese American Citizens League  
MomsRising  
National Asian American Pacific Islander Mental Health Association  
National Asian Pacific American Families Against Substance Abuse  
National Asian Pacific American Women's Forum  
National Association of Social Workers  
National Council of Asian Pacific Americans (NCAPA)  
National Disability Rights Network (NDRN)  
National Federation of Filipino American Associations  
Prevent Blindness  
SHK Global Health  
SIECUS: Sex Ed for Social Change  
Sojourners  
South Asian Public Health Association  
Southeast Asia Resource Action Center (SEARAC)

**State & Local Organizations**

Asian Pacific Community in Action  
Asian Pacific Islander Breastfeeding Task Force  
AWAAZ  
Bhutanese Community Association of Pittsburgh (BCAP)  
BreastfeedLA  
Coalition for Asian American Children and Families  
Health Equity Solutions  
Karen Society of Nebraska  
National Association of Social Workers - Texas Chapter  
North Carolina Justice Center  
Oklahoma Micronesian Coalition  
Pacific Asian Counseling Services  
Papa Ola Lōkahi  
The Cambodian Family Community Center  
The Children's Partnership