Accommodation of Persons With Limited English Proficiency
TMA Office of General Counsel

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Introduction
On May 18, 2016, the U.S. Department of Health and Human Services (HHS) published final rules that implement Section 1557 of the Affordable Care Act (ACA). Section 1557 prohibits certain entities that administer “health programs and activities” from discriminating against individuals on the basis of race, color, national origin, sex, age, or disability. Although Section 1557 does not mention discrimination against individuals on the basis of language, the rules follow a long-established precedent interpreting a prohibition on national origin discrimination to require entities to take reasonable steps to provide meaningful access to individuals with limited English proficiency (LEP). The reasonable steps that a physician must take depend on a set of flexible standards that take into account factors such as the nature and importance of the patient communication, the frequency with which the covered entity encounters the language spoken by the individual, the resources available to the physician, and other factors. Ensuring that a physician complies with these factors is important because failing to do so could be a violation of Title VI of the Civil Rights Act of 1964 (CRA) and Section 1557 of the ACA and could carry with it significant penalties, including loss of federal financial aid. This white paper outlines the responsibility that physicians have with regard to treating LEP patients.

History
The final rule’s implementation of Section 1557 of the ACA continues a long precedent of prohibiting discrimination against LEP persons that begins with the Civil Rights Act of 1964.

The Civil Rights Act of 1964
Title VI of the CRA provides that no person shall, “on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.” Congress’ authority to pass Title VI was derived from the Spending Clause of the Constitution. Thus, the regulations based on Title VI that prohibit discrimination against LEP persons are expressly made applicable only to those physicians and health care providers who accept federal funds or payments. This is important because this applicability standard has continued through the most recent adoption of the final rules implementing the ACA’s Section 1557. If an entity (or person) is found in violation of Title VI, it thus may lose its federal funding.

Several factors led to the passage of the CRA. The legislative history of Title VI indicates that discrimination in health care was certainly a key contributor to the enactment of Title VI. At the time Title VI was passed, legal segregation in hospitals and other health care facilities had ended only recently. Regulations promulgated immediately after the enactment of Title VI reflect its message. However, even after the passage of the CRA, there was disagreement as to just how far-reaching the new regulations were. As with many laws, the breadth of Title VI protections was not understood fully until it was considered by the U.S. Supreme Court.

Supreme Court Interpretation

In a 1974 case, Lau v. Nichols, the Supreme Court was asked to determine whether the decision by the San Francisco Unified School District (SFUSD) not to provide special educational services to Chinese-speaking children violated Title VI. The court ruled that by not offering educational services in Chinese, SFUSD was in violation of Title VI. Although the school was not intentionally discriminating against Chinese students, the court found that the absence of classes taught in Chinese had a discriminatory effect. Essentially, the court’s decision reflected a view that language is so closely intertwined with national origin that language-based discrimination is effectively a proxy for national origin discrimination. Though the facts of the case had to do with language assistance in education, the court’s opinion was understood to apply to all organizations that receive federal assistance (and are therefore covered by Title VI). The Lau case thus confirmed Title VI’s prohibition on discrimination against LEP persons, though a subsequent Supreme Court case did apply some limits to a LEP person’s rights under Title VI.

Executive and Administrative Regulation

On Aug. 11, 2000, President Bill Clinton issued Executive Order (EO) No. 13166. EO 13166 was implemented 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. EO 13166 cites Title VI of the CRA as its underlying legal basis, but also notes that it “is intended only to improve the internal management of the executive branch and does not create any right or benefit, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers or employees, or any person.”

EO 13166 ordered every federal agency that provides financial assistance to nonfederal entities to publish guidance on how its recipients can provide meaningful access to LEP persons and thus comply with Title VI. The U.S. Department of Justice (DOJ) was tasked with adopting guidelines for other federal agencies to follow in adopting their respective guidelines for providing meaningful access to LEP persons.

HHS followed DOJ’s lead and adopted guidance first in August 2000, followed by revised guidance in August 2003. The HHS LEP Guidance set the standard for Title VI compliance regarding LEP discrimination until the passage of the Affordable Care Act.

The Affordable Care Act

President Obama signed the Affordable Care Act into law on March 23, 2010. Section 1557 of the ACA is the nondiscrimination provision of the law, prohibiting discrimination on the basis of race, color, national origin, sex, age,

4. In the 2001 case, Alexander v. Sandoval, the court held that a regulation enacted under Title VI of the CRA did not include a private right of action based on evidence of disparate impact (policies and practices that appear neutral, but have a discriminatory effect), as policies with a disparate impact on minorities are presumed to be unintentional discrimination. 532 U.S. 275, 293 (2001). This part of the holding in Sandoval overruled part of the court’s holding in Lau that seemed to recognize private rights of action for both intentional discrimination and disparate impact on minorities.
6. Id.
or disability in a “health program or activity, any part of which is receiving Federal financial assistance … or under any program or activity that is administered by an Executive Agency.” On May 18, 2016, HHS published final rules implementing Section 1557. The rules, found in Title 45 Code of Federal Regulations Part 92, lay out an important compliance framework for physicians and health care providers regarding all types of discrimination, including discrimination against LEP persons. This framework includes factors to help entities determine the reasonable steps they must take to provide meaningful access to LEP persons, required notices entities must make available, and assurances that entities must make when applying for federal financial assistance.

Key Provisions of the Final Rules

Prior to the passage of the ACA and the subsequent adoption of the Section 1557 final rules, no statute or regulation laid out guidelines for complying with Title VI prohibitions on discrimination based on language proficiency. As discussed above, instead of legislative direction, administrative agencies had been providing policy guidance that, rather than establishing hard and fast rules, formulated broad principles that would have guided entity compliance and agency enforcement. Fortunately, the final rules mostly combine and harmonize already established principles and thus generally represent mere codification of existing policies. The final rules still do, however, introduce new features into the LEP regulatory scheme, so even if an entity had been carefully monitoring compliance according to previous HHS LEP Guidance, the entity should still examine its compliance status in light of the final rules.

As a threshold issue, the final rules establish the types of entities that are subject to the rules and also identify the LEP populations to which entities should provide meaningful access. Further, the final rules, as did previous HHS guidance, recognize that it may not be reasonable for every type of entity to subject itself to prohibitive costs in order to provide meaningful access to LEP individuals. The rules thus allow for flexibility in determining the extent to which entities provide meaningful access and lay out factors in making that determination. The rules also lay out other meaningful access requirements that relate to the quality of interpretation and translation services an entity makes available. The most notable additions to previous guidance are the requirements that certain notices be posted and that certain entities appoint a compliance officer and establish a grievance process for complaints. These requirements are described in further detail below.

Which Entities Are Subject to the HHS LEP Guidance?

In the preamble to the final rules, HHS indicates that they would apply to any entity that has a health program or activity, any part of which receives federal financial assistance from HHS. The rules refer to this class of entities as “covered entities.” Covered entities may include hospitals, home health agencies, laboratories, community health centers, state Medicaid agencies, and physicians and physician practices.

With respect to physicians specifically, HHS estimates that the rules “would likely cover almost all licensed physicians.” This is because most physicians participate in at least one federal, state, or local health program that receives federal financial assistance; many physicians, for instance, participate in Medicaid or receive “meaningful use” payments (or the successor to meaningful use payments).16

13. This is not the same definition of “covered entities” used in either the federal HIPAA privacy regulations or Texas state law—so one should be careful not to confuse the terms. A “covered entity” under HIPAA or Texas state law may not be a “covered entity” for the purposes of the Section 1557 final rules.
15. For instance, HHS noted that approximately 614,000 physicians out of 850,000 (or 72 percent) accepted Medicaid payments in 2010.
16. 81 Fed. Reg. 31,445. The final rules specifically mention that the Medicare Access and CHIP Reauthorization Act gradually eliminates the “meaningful use” payments and transitions it to a similar payment structure.
Some physicians receive financial assistance directly, while others may receive it through another entity. The rules make no distinction between physicians who receive financial assistance directly or indirectly, stating that a recipient of federal financial assistance is “an entity to which Federal financial assistance is extended directly or through another recipient, including any successor, assignee, or transferee of a recipient.”

Despite there being no distinction between direct and indirect recipients, there is a difference between a physician who is the intended recipient of federal financial aid and one who is merely an economic beneficiary of the aid. When a physician is a direct recipient, the case is straightforward. But when a physician receives funds from or through another entity, the determination of whether a physician is a “recipient of federal financial assistance” can be quite nuanced, and turns on whether the physician was the intended recipient of the assistance.

For instance, physicians who contract with health plans would not, by virtue of the contract alone, necessarily be considered a “covered entity.” This is because Congress may have intended the financial assistance to assist the issuer, or it may have intended the assistance to pass through the issuer to the physician. If the physician contracts with a health insurance issuer and the issuer receives federal financial assistance in the form of a premium tax credit or a cost-sharing reduction, the physician is not the “intended recipient” of that assistance (the physician merely benefits because the issuer has a deeper pool of money from which to pay physician fees) and is therefore not a covered entity by virtue of the physician’s contract with the issuer. On the other hand, if the physician contracts with a health issuer and the issuer receives a capitated payment from a state Medicaid agency under a managed care contract, it is more likely that the physician was indeed the “intended recipient” of that financial assistance. In this latter case, the financial assistance is intended to be a payment for the physician’s services, and is not simply, as in the former case, coincidental with and independent of the physician’s contract with the issuer.

Notably, though, physicians who receive only Medicare Part B payments are not included.

The table on the next page lists example situations and how HHS resolves the situation in determining which entity is the “covered entity” by being the intended recipient of the financial assistance.

Most physicians will find themselves subject to Section 1557 and must thus comply with the requirements of the rules. Among other things, this means a physician is obligated to take reasonable steps to ensure that meaningful access to services and programs is provided to eligible LEP persons.

Example Situation | What the Rules Require
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A doctor is an employee of a hospital, and the hospital receives federal financial assistance. | The hospital’s program is the relevant “health program or activity,” and it is the hospital that will be held accountable for discrimination under Section 1557.

A doctor contracts as an individual to provide health services at a free neighborhood clinic that receives federal financial assistance. | The clinic is the recipient of federal financial assistance and liable for discrimination; the doctor is simply a contractor who is assisting the clinic in performing clinic services.

A doctor has a private medical practice that receives federal financial assistance, and the doctor, through her practice, works as an attending physician at a hospital. | The doctor’s practice is providing the services at the hospital, and thus the practice is liable for the discrimination. (The hospital also may be responsible for discrimination by the doctor’s practice that occurs at the hospital.)

A solo medical practice (whether incorporated or not) receives federal financial assistance. | The practice is a “covered health program or activity” subject to the rules. The rules define a “recipient” to include an individual.

A medical student receives federal educational loans. | The educational institution — not the student — is the recipient of the federal financial assistance in that circumstance. Although the money is paid directly to the student, the university or other educational institution is the intended recipient, consistent with longstanding regulations implementing civil rights laws.

This nuanced determination may be necessary for some, but as the rules stated, most physicians will find themselves subject to Section 1557 and must thus comply with the requirements of the rules. Among other things, this means a physician is obligated to take reasonable steps to ensure that meaningful access to services and programs is provided to eligible LEP persons. Physicians should consult with their legal counsel to determine the application of the rules to their particular situation.

**Who Is a Limited English Proficient Individual?**

An LEP person is an individual “whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English.” Importantly, covered entities must take reasonable steps to provide meaningful access not just to those LEP persons with whom the entities have actual contact; rather, they must do so for LEP persons who are “eligible to be served or likely to be encountered” in the covered entity’s health programs and activities. In explaining the reasoning behind requiring access for those individuals beyond with whom the entity actually has contact, HHS stated:

A covered entity must be prepared to take reasonable steps to provide meaningful access to individuals beyond those who actually walk into, or contact, that entity. Where a covered entity is likely to encounter, but is unprepared to assist, individuals of particular national origin groups in

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22. 45 C.F.R. §92.4.
23. 45 C.F.R. §92.201(a).
the languages in which they communicate, those individuals are unlikely to seek services from, or participate in, the entity’s health programs or activities, thereby perpetuating barriers to individuals’ access to care.24

To What Extent Must a Physician Take Reasonable Steps to Satisfy the Physician’s Obligation?

The final rules require covered entities to take “reasonable steps” to provide meaningful access to LEP persons. But how is a covered entity to determine what is “reasonable”? The steps required to be taken by a large hospital serving an area with a high LEP population would be very different from those required of a small clinic serving an area with very few LEP persons.

The rules do offer some guidelines, and previous policy guidance also may be instructive. The rules provide that to determine a covered entity’s compliance, HHS will:

1. Evaluate, and give substantial weight to, the nature and importance to the LEP individual of the health program or activity and the particular communication at issue; and

2. Take into account other relevant factors, including whether a covered entity has developed and implemented an effective written language access plan that is appropriate to its particular circumstances.25

The one factor that HHS did specify — the creation of a written language access plan — was identified to remind covered entities that they may wish to take action to prepare to provide language assistance services to the LEP persons they will serve or encounter.26 Though this is the one specified factor, HHS did reiterate that a covered entity’s adoption of this plan is voluntary and does not create a guarantee of compliance with the rules.

HHS opted not to list more extensive or comprehensive relevant factors in order to avoid “an unworkable regulatory scheme in the attempt to capture any possible factor that might be relevant in some circumstances.”27 But while HHS was reluctant to try articulating every possible relevant factor in rule, it did offer sample factors in the preamble discussion that it may consider when determining a covered entity’s compliance with the rules. They include:

• The length, complexity, and context of the communication;

• The prevalence of the language in which the individual communicates among those eligible to be served or likely to be encountered by the health program or activity;

• The frequency with which a covered entity encounters the language in which the individual communicates;

• Whether a covered entity has explored the individual’s preference, if any, for a type of language assistance service, as not all types of language assistance services may work as well as others in providing an individual meaningful access to the covered entity’s health program or activity;

• The cost of language assistance services and whether a covered entity has availed itself of cost-saving opportunities; and

• All resources available to the covered entity, including the entity’s capacity to leverage resources among its partners or to use its negotiating power to lower the costs at which language assistance services could be obtained.28
Prior to the adoption of the final rules, HHS had offered four factors in its HHS LEP Guidance that each covered entity used as part of the individualized assessment it made in determining what steps would be reasonable for it take. Those factors aimed to create a solution that ensures meaningful access by LEP persons while not imposing undue burdens on small businesses and others without large budgets. Those factors were:

1. The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee;
2. The frequency with which LEP individuals come into contact with the program;
3. The nature and importance to people’s lives of the program, activity, or service provided by the program; and
4. The resources available to that grantee/recipient and costs.29

Clearly, there is some overlap between the previous guidance and the final rules. HHS, for instance, will still consider the “nature and importance” of health programs under the rules as it had under previous guidance, and HHS also appears to have intended to encompass the other factors when it adopted the rules to state that HHS would consider other “relevant factors.” Compliance with the HHS LEP Guidance thus may help a physician comply with the final rules. There is no indication that HHS intended the final rules to completely abrogate previous guidance so the HHS LEP Guidance still may have value in helping a covered entity evaluate the reasonable steps it must take to provide meaningful access to LEP persons.30

If a Physician Must Provide Language Services, What Requirements Apply?

HHS clarifies that language assistance services that are required as “reasonable steps to provide meaningful access” should be free of charge, be accurate and timely, and protect the privacy and independence of the LEP person.31 The final rules, for the most part, express a codification of requirements laid out in previous HHS guidance.

• The “free of charge” requirement is straightforward, but the requirements relating to accuracy, timeliness, and privacy and independence require deeper consideration.

• In the final rules, HHS declined to adopt prescriptive time limits and instead opted for a flexible “timely” standard. Language assistance is timely “when it is provided at a place and time that ensures meaningful access to persons of all national origins and avoids the delay or denial of the right, service, or benefit at issue.”32 HHS acknowledges that “there is no one definition of ‘timely’ that applies to every type of interaction with every covered entity at all times. … [A] determination of whether language assistance services are timely will depend on the specific circumstances of each case.”33

• To enforce the requirements that language assistance services be provided accurately and in a way that protects privacy and independence, HHS has established certain requirements regarding how those services are provided and by whom. These relate to: (1) the qualifications for providers of interpretation and translation services; (2) the use of family members, friends, and staff to provide language services; and (3) the use of video interpreting services.
Qualified Interpreters and Translators

The final rules require that when oral interpretation is a reasonable step to provide meaningful access, a covered entity must offer that interpretation from a “qualified interpreter.” Similarly, covered entities must use a “qualified translator” when translating written content. In the HHS LEP Guidance, HHS offered more guidelines regarding the standards constituting “qualified” interpretation or translation. Some of the standards described in that guidance are present in the final rules’ definition of a “qualified” interpreter or translator:

• A “qualified interpreter” is one who, via a remote interpreting service or an on-site appearance:
  1. Adheres to generally accepted interpreter ethics principles, including client confidentiality;
  2. Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and
  3. Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology.

• A “qualified translator” is one who:
  1. Adheres to generally accepted translator ethics principles, including client confidentiality;
  2. Has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and
  3. Is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology.

Notably absent from this list of qualifications is the requirement that one have a certification to be “qualified.” HHS was reluctant to codify this factor — even though it is still a helpful factor in determining whether one is qualified — for several reasons. HHS feared that requiring certification for interpreters, for instance, would “unduly narrow the pool of qualified interpreters,” recognizing that one does not need to be certified to be “qualified” for the purpose of the rules. HHS also recognized that there is not one standard certification entity and there would thus be no way of ensuring similar quality across certification bodies. Finally, HHS did not want the certificate to be seen as a dispositive factor for being “qualified,” because other factors could make one unqualified notwithstanding the person’s certification.

Family Members and Staff

In addition to laying out characteristics of a qualified interpreter, the rules also place restrictions on providing language services. A covered entity may not:

• Require an LEP person to provide his or her own interpreter;
• Rely on an adult accompanying an LEP person (except in cases of emergency or when the LEP person specifically requests it);
• Rely on a minor child to interpret (except in cases of emergency); or

34. 45 C.F.R. §92.201(d).
35. Id.
37. 45 C.F.R. §92.4.
39. Id.
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- Rely on staff members, other than a member of a covered entity's workforce who is designated by the covered entity to provide oral language assistance as part of the individual's current, assigned job responsibilities and who has demonstrated to the covered entity that he or she:

1. Is proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology; and

2. Is able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary language.

It is important to note that an LEP person is not required to use language assistance services, and the LEP person may very well insist on using an accompanying adult or minor as an unofficial source of interpretation. The rules thus dictate the types of language assistance on which a covered entity is permitted to rely. A covered entity for which providing interpretation services is a reasonable step must make such services available, but that does not mean a patient cannot forego the covered entity's interpreter in favor of a family member or friend. The covered entity must respect a patient's request to use whatever language assistance with which the patient is comfortable.

These restrictions represent a synthesis with previous HHS guidance on the subject. Neither the final rules nor the preamble discussion explore the justifications behind this rule, so the previous HHS guidance is still a good resource that explains the reasoning behind some of these restrictions.

Video Remote Interpretation Services

HHS allows for a covered entity to provide interpretation services through video remote interpreting services, as long as the services meet the quality standards in the rules. The rules establish that a covered entity providing interpreting services this way must provide:

1. Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images; or irregular pauses in communication;

2. A sharply delineated image that is large enough to display the interpreter's face and the participating individual's face regardless of the individual's body position;

3. A clear, audible transmission of voices; and

4. Adequate training to users of the technology and other involved individuals so they may quickly and efficiently set up and operate the video remote interpreting.

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40. 445 C.F.R. §92.201(c).
41. 45 C.F.R. §92.201(g).
42. Previous HHS guidance explains the following: “Some LEP persons may feel more comfortable when a trusted family member or friend acts as an interpreter. However, when a recipient encounters an LEP person attempting to access its services, the recipient should make the LEP person aware that he or she has the option of having the recipient provide an interpreter for him/her without charge, or of using his/her own interpreter. Although recipients should not plan to rely on an LEP person's family members, friends, or other informal interpreters to provide meaningful access to important programs and activities, the recipient should, except as noted below, respect an LEP person's desire to use an interpreter of his or her own choosing (whether a professional interpreter, family member, or friend) in place of the free language services expressly offered by the recipient. However, a recipient may not require an LEP person to use a family member or friend as an interpreter.” 68 Fed. Reg. 47,317.
43. The government believes that children, and even most bilingual adults, are unlikely to be familiar with medical terminology in a way that allows them to effectively interpret what the physician is trying to convey to the patient. This will undoubtedly inhibit the translator's ability to give accurate information to the patient. Furthermore, the government believes patients may be hesitant to convey sensitive medical information via a family member or friend, which may lead to inaccurate diagnoses.
44. 45 C.F.R. §92.201(f).
Must a Physician Adopt a Written Language Access Plan?

Previous HHS guidance has suggested the adoption of a written language access plan to help covered entities ensure compliance with Section 1557. The final rules do not require a written plan, but, notably, the one listed factor in the rules that HHS will consider in determining compliance is whether the entity has developed and implemented an effective written access plan.45

There is no form or required content for a written access plan. The preamble discussion for the rules indicates that a plan should be appropriate to the particular circumstances of the covered entity, tailoring the plan to the entity’s particular health programs and activities, its size, geographic location, and other unique factors.46 Without outlining a minimum standard for plans, HHS encourages entities to consider whether and how they can create a plan for complying with LEP requirements. Nevertheless, HHS does list a few elements that may be found in effective language access plans:

- Address how the entity will determine an individual’s primary language, particularly if the language is an unfamiliar one;
- Identify a telephonic oral interpretation service to be able to access qualified interpreters when the need arises;
- Identify a translation service to be able to access qualified translators when the need arises;
- Identify the types of language assistance services that may be required under particular circumstances; and
- Identify any documents for which written translations should be routinely available.47

What Else Must a Physician Do to Comply With Section 1557 and the Rules?

The final rules require covered entities to do three important actions that previous guidance did not necessarily require: make assurances, provide specific notices, and adopt a grievance procedure. These actions are not necessarily specific to LEP services, but because the requirements necessarily include LEP services, the requirements are discussed here.

Assurances

The rules require that each entity applying for federal financial assistance must submit a written assurance of its compliance with Section 1557.48

Notices and Taglines

The final rules require that each covered entity, regardless of the extent of the reasonable steps that entity must take to provide meaningful access, “take appropriate initial and continuing steps” to post notice that includes the following:

- A statement that the covered entity does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities;
- A statement that the covered entity provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities;

45. 45 C.F.R. §92.201(b)(2).
46. 81 Fed. Reg. 31,414 (May 18, 2016)
47. 81 Fed. Reg. 31,415 (May 18, 2016)
48. 45 C.F.R. §92.5.
• A statement that the covered entity provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to provide meaningful access to individuals with limited English proficiency;

• An explanation of how one obtains the offered aids or language assistance services;

• An identification of the employee responsible for coordinating efforts to comply with the rules, if applicable;

• The availability of the grievance procedure, if applicable, and how to file a grievance; and

• An explanation of the process to file a discrimination complaint with the HHS Office of Civil Rights.49

In addition to this required notice, a covered entity must post a tagline in at least the top 15 languages spoken by LEP individuals in the state.50 A tagline is a "short statement written in non-English languages that indicate the availability of language assistance services free of charge."51 A sample tagline is in Attachment A of this document. A list of the top 15 languages spoken by LEP individuals in Texas is found in Attachment C.52 HHS also will provide sample translations in the necessary languages.53

Form and Location of Notice and Taglines

This notice and taglines must be posted in a “conspicuously visible font size.”54 They must be posted in both significant publications and communications targeted to beneficiaries of the entity’s health programs and activities (unless the publications are too small — see the section on additional statements below), in conspicuous physical locations where the entity interacts with the public, and also in a conspicuous location on the covered entity’s website.55

Additional Statement of Nondiscrimination in Small-Sized Communications

Each covered entity is obligated to post, also in a conspicuously visible font size, in significant publications that are small-sized, two things:

1. A statement that the covered entity does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities; and

2. The required taglines in the top two languages spoken by LEP individuals in the state.56

Deadline for Posting

Each covered entity must post the notice and taglines, and must include the additional statement of nondiscrimination in small-sized communications, no later than Oct. 16, 2016.57
Grievance Procedures

The final rules require covered entities with 15 or more employees to take two proactive steps to comply with Section 1557 and the rules:

1. Adoption of a grievance procedure; and
2. Designation of one employee to coordinate compliance efforts.

The grievance procedure must incorporate due process standards and provide for “prompt and equitable resolution of grievances” relating to compliance with Section 1557 and the rules.

The compliance coordinator coordinates an entity’s efforts to comply with Section 1557 and the final rules, including investigation of any grievances the entity receives about its actions that are allegedly in violation of Section 1557 or the rules.

A sample grievance procedure is in Attachment B.

How Are These Rules Going to Be Enforced?

Section 1557 provides that any enforcement mechanism available under the statutory prohibitions on discrimination on the basis of race, color, national origin, sex, age, or disability are available for enforcement under Section 1557. Those mechanisms include informal means such as “requiring covered entities to keep records and submit compliance reports to the Office of Civil Rights, conducting compliance reviews and complaint investigations, and providing technical assistance and guidance.”

If informal methods cannot correct noncompliance, HHS is authorized to enforce compliance by suspension of, termination of, or refusal to grant or continue federal financial assistance, or by referral to DOJ with a recommendation to bring proceedings to enforce any rights of the United States.

The final rules also make it clear that a private right of action and damages (including compensatory damages) for violations of Section 1557 are available to the same extent that such are available under the other mentioned civil rights laws.

Conclusion

As HHS discussed in the preamble to the final rules, a vast majority of physicians will be subject to the rules and thus must comply with Section 1557’s prohibition on discrimination on the basis of race, color, national origin, sex, age, or disability. This document has focused on the obligations under that section with respect to discrimination on the basis of national origin as it relates to individuals with limited English proficiency. The extent to which each physician or physician practice must take steps to provide access to their health programs or activities is flexible and is based on each physician’s or physician practice’s circumstances.

58. 45 C.F.R. §92.7.
59. 45 C.F.R. §92.7(b)
60. 45 C.F.R. §92.7(a)
61. 42 U.S.C. §18116(a)
63. Id.
64. 45 C.F.R. §92.301.
Where to Look for More Information

The following websites should help physicians and other covered entities further familiarize themselves with the guidance as well as their obligations under Title VI:

- Department of Health and Human Services Office for Civil Rights LEP website
  www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/

- Section 1557 of the Affordable Care Act Information
  www.hhs.gov/civil-rights/for-individuals/section-1557/

- Final Rule on Nondiscrimination in Health Programs and Activities

- Revised HHS LEP Guidance (published Aug. 8, 2003)
  www.hhs.gov/sites/default/files/ocr/civilrights/resources/specialtopics/lep/lepguidance.pdf

- General LEP Information
  www.lep.gov/

- Frequently Asked Questions
  www.lep.gov/faqs/faqs.html

- Summary of HHS's Final Rule on Nondiscrimination in Health Programs and Activities

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ATTACHMENT A

Sample Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

DISCRIMINATION IS AGAINST THE LAW

[Name of covered entity] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. [Name of covered entity] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

[Name of covered entity]

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  • Qualified sign language interpreters
  • Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
  • Qualified interpreters
  • Information written in other languages

If you need these services, contact [Name of Civil Rights Coordinator].

If you believe that [Name of covered entity] has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: [Name and Title of Civil Rights Coordinator], [Mailing Address], [Telephone Number ], [TTY Number — if covered entity has one], [Fax], [Email]. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, [Name and Title of Civil Rights Coordinator] is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave. SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Sample Nondiscrimination Statement for Significant Publications and Significant Communications That Are Small-Sized:

[Name of covered entity] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Sample Tagline Informing Individuals With Limited English Proficiency of Language Assistance Services:

ATTENTION: If you speak [insert language], language assistance services are available to you free of charge. Call 1-xxx-xxxx-xxxx (TTY: 1-xxx-xxxx-xxxx)
ATTACHMENT B

Sample Section 1557 of the Affordable Care Act Grievance Procedure

It is the policy of [Name of Covered Entity] not to discriminate on the basis of race, color, national origin, sex, age, or disability. [Name of Covered Entity] has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR Part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of [Name and Title of Section 1557 Coordinator], [Mailing Address], [Telephone Number], [TTY Number — if covered entity has one], [Fax], [Email], who has been designated to coordinate the efforts of [Name of Covered Entity] to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age, or disability may file a grievance under this procedure. It is against the law for [Name of Covered Entity] to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

• Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.

• A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

• The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of [Name of Covered Entity] relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

• The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of his or her right to pursue further administrative or legal remedies.

• The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the (Administrator/Chief Executive Officer/Board of Directors/etc.) within 15 days of receiving the Section 1557 Coordinator’s decision. The (Administrator/Chief Executive Officer/Board of Directors/etc.) shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age, or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave. SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at: www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

[Name of covered entity] will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or ensuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.
The Top 20 Languages Spoken in Texas by Individuals With Limited English Proficiency

The table below is provided by the U.S. Department of Health and Human Services, based on 2014 U.S. Census Bureau data. Physicians should check for updates, as the language rankings may change.

<table>
<thead>
<tr>
<th>Language</th>
<th>Number of Speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Spanish</td>
<td>2,966,475</td>
</tr>
<tr>
<td>2. Vietnamese</td>
<td>115,640</td>
</tr>
<tr>
<td>3. Chinese</td>
<td>71,139</td>
</tr>
<tr>
<td>4. Korean</td>
<td>30,852</td>
</tr>
<tr>
<td>5. Arabic</td>
<td>22,002</td>
</tr>
<tr>
<td>6. Urdu</td>
<td>18,041</td>
</tr>
<tr>
<td>7. Tagalog</td>
<td>17,982</td>
</tr>
<tr>
<td>8. French</td>
<td>12,673</td>
</tr>
<tr>
<td>9. Hindi</td>
<td>12,656</td>
</tr>
<tr>
<td>10. Persian (Farsi)</td>
<td>11,610</td>
</tr>
<tr>
<td>11. German</td>
<td>10,664</td>
</tr>
<tr>
<td>12. Gujarati</td>
<td>9,864</td>
</tr>
<tr>
<td>13. Russian</td>
<td>7,004</td>
</tr>
<tr>
<td>14. Japanese</td>
<td>6,620</td>
</tr>
<tr>
<td>15. Laotian</td>
<td>5,709</td>
</tr>
</tbody>
</table>

The translated resources for covered entities for providing taglines under the above languages are available at www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources. TMA shall have no liability for any use or reliance by a user on these third-party websites.