November 6, 2015

Sylvia M. Burwell, Secretary
U.S. Department of Health and Human Services
Office for Civil Rights
Hubert H. Humphrey Building Room 509F
200 Independence Avenue SW.
Washington, DC 20201

RE: Nondiscrimination in Health Programs and Activities, 1557 NPRM (RIN 0945–AA02)

Dear Secretary Burwell,

On behalf of the American Academy of Family Physicians (AAFP), which represents 120,900 family physicians and medical students across the country, I write in response to the Nondiscrimination in Health Programs and Activities proposed rule published by the Office of Civil Rights in the September 8, 2015 *Federal Register*. HHS proposes this regulation to implement Section 1557 of the *Affordable Care Act* which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities.

We congratulate you on this regulation since it is AAFP's longstanding policy on health care to support the concept of basic health care services for everyone regardless of social, economic or political status, race, religion, gender or sexual orientation. Conversely, AAFP policy on patient discrimination opposes all discrimination in any form, including but not limited to, that on the basis of actual or perceived race, color, religion, gender, sexual orientation, gender identity, ethnic affiliation, health, age, disability, economic status, body habitus or national origin.

However the proposed rule also includes requirements for effective communication for individuals with disabilities and enhanced language assistance for people with limited English proficiency. It is AAFP policy on culturally proficient, health care to be cognizant of cultural differences and how addressing those differences can improve the quality of care. The AAFP urges all medical schools and family medicine residencies to educate students and residents about cultural and ethnic differences. The AAFP recommends that all physicians learn about and respect the cultural/ethnic background of their patients. Sensitivity to cultural and individual perceptions of health, family and illness should be incorporated into a patient's care and the development of treatment plans as appropriate. When treating patients whose language differs from that of the physician, the physician must follow federal mandates to provide appropriate interpretive services.

Finally, it is the AAFP's stance on culturally sensitive interpretive services to support policy to make funding available for culturally sensitive interpretive services for those who have limited English proficiency, or who are deaf and mute, or who are otherwise language impaired and also requests that the funding be made available directly to the interpreters for culturally sensitive interpretive services.

In the proposed rule HHS estimates that the impact, "on small entities for training equals $293 million. Dividing this amount by the number of small entities in Table 6 gives an average burden of $1,135." Since the related AAFP stance calls for funding to be made available for culturally sensitive interpretive services for those who have limited English proficiency and also because small practices already operate on such thin margins, the AAFP strongly believes that HHS must procure the necessary funding to address and offset the estimated $1,135 burden on small entities. We have significant concerns that primary care practices are already taking a financial loss for treating patients that require interpretive services because of the historical undervaluation of primary cares services in the resource-based relative value scale system. Medicare and Medicaid reimbursement for essential primary care services are simply inadequate and interpretive services remain costly. If the patient reschedules or does not appear for the appointment, the practice must still reimburse the interpreter. We believe that HHS must fund these increased costs practices will bear to comply with this proposed rule. If this cannot be accomplished, we call on HHS to eliminate this requirement from this proposed rule.

For any questions you might have please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

Robert L. Wergin, MD, FAAFP
Board Chair

CC: Claudia Adams