Healthcare Provider Obligations For Individuals With Limited English Proficiency

Insights
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This summer I wrote about the dangers of English-only policies in this age of multiculturalism (for more, click here). These policies tend to emerge more frequently in the healthcare workplace, the reason being – the provision of quality care is the utmost goal and sometimes that requires everyone to speak the same language. But, what happens when it is the patient who is culturally diverse from the workforce? What must healthcare providers do in response? The Department of Health and Human Services has the answer: covered entities must provide language services to people whose primary language is not English in a more robust way than ever before.

A Lesser Standard of Care for Non-English Speakers?
Within the medical and scientific communities, it is well settled that language barriers can hinder one's access to healthcare services and can compromise the quality of care received. Unfortunately, this often translates to increased adverse outcomes among non-English speaking patients. While federal law (e.g., Title VI of the Civil Rights Act, Executive Orders, and the Emergency Medical Treatment and Active Labor Act) has long required healthcare providers to make care accessible to individuals with Limited English Proficiency (LEP), these requirements were – at least arguably – somewhat relaxed. For example, until recently, healthcare providers were only required to provide translation services in a "competent" way. So a bilingual nurse, family member or other informal translator may have been sufficient, even if there had been no training or certification, or knowledge of specialized medical terminology.

Given the rapidly changing demographics of the United States and data suggesting that patients with LEP were still receiving substandard care (in addition to a surplus of other issues), the Obama Administration set out to drastically reform the country's healthcare system . In 2010, the now famous (or infamous, depending who you ask) Affordable Care Act (ACA) became law.

Section 1557 of the Affordable Care Act Mandates (More) Meaningful Access
At this point, we have all heard of the ACA, perhaps better known of as Obamacare. There is a good chance that you are also familiar with Section 1557 of the ACA, along with HHS's May 2016 Final Rule implementing it, which prohibits discrimination by "covered entities" on a variety of bases (e.g., because of one's national origin) in the provision and/or administration of certain health programs and activities. In fact, one of the sexier aspects of the Final Rule – that is, the part that literally deals with discrimination because of sex – has garnered significant national media attention lately (for

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more on that, click here). But, there is a chance you are unfamiliar with one of the less glamourous provisions of the Final Rule: the provision that protects individuals with LEP. It is through this provision that the ACA seeks to better accommodate the needs of an increasingly diverse patient population.

As part of its prohibition of discrimination on the basis of one's national origin, the Final Rule implementing Section 1557 of the ACA requires covered entities (i.e., virtually every healthcare provider) to provide meaningful access to each individual with LEP who is eligible to be served or likely to be encountered within the entities' health programs and activities. Notably, this can apply to certain family members of the patient, even if the patient does not require this access himself.

According to HHS, what constitutes "meaningful access" is flexible and content-specific. This may include providing oral language assistance via qualified interpreters. But, it may not include the use of low-quality video remote interpreting services or reliance on unqualified staff or translators, no matter how "competent" they might be. Section 1557, through the Final Rule, also obligates covered entities to post translated information informing individuals with LEP of their rights and that language assistance services are available free of charge. To minimize the burden of providing this information in a compliant way, the Office for Civil Rights (OCR) has prepared translated resources for a covered entity's use (available here).

Failure to Comply Can Be Bad for Business

While some of the earlier vehicles requiring the delivery of meaningful access to healthcare to individuals with LEP allowed for a private right of action, the complained of conduct generally had to be "intentional." This is no easy burden. Section 1557 of the ACA – through the Final Rule implementing it – expanded this private right of action, such that patients can now file suit over discrimination that is unintentional. Or, as we say in the employment law world: claims for disparate impact. These claims are typically easier to prove and open the door for class-based lawsuits. It should be obvious that an easier burden plus multiple plaintiffs (plus possible compensatory damages and attorneys' fees) equals increased cost.

Aside from individual (or class-based) lawsuits, the government can also compel compliance. The penalty for non-compliance can be as insignificant as mandated implementation of a language access plan (i.e., the plan that speaks to an organization's language access capabilities), or as serious as a total loss of federal funding. Also obvious: that healthcare providers want to avoid the latter, potentially calamitous consequence.

The Trump Card and Practical Tips for Minimizing Risk

The requirement that a covered entity provide meaningful access to individuals with LEP under Section 1557 has been in effect since October 2016 (though, there are differing deadlines associated with Section 1557 compliance, depending on the provision). While perhaps not at the top of the OCR's priority list, Section 1557 (including, but not limited to the requirements discussed in this article), are being enforced. To avoid a visit from the government or a class action lawsuit by an enterprising plaintiff's attorney, healthcare providers will want to have their culturally diverse houses in order. To

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plaintiff's attorney, healthcare providers will want to have their culturally diverse houses in order. To do this, covered entities should ensure the required notices are posted, evaluate the nature and importance of the covered health program and how it is being communicated, and consider whether the implementation of a language access plan is appropriate. Covered entities should also train the appropriate staff on their Section 1557 obligations.

There is one other thing that further complicates matters: the Trump card. And, of course by "card," I mean President-Elect. President-elect Trump has frequently communicated his commitment to repeal and replace the ACA. To further this goal, he has chosen Rep. Tom Price (R-GA) – an outspoken opponent to the ACA – to head HHS in his administration. Speaker Paul Ryan has also promised to repeal the ACA, and is already taking steps to achieve this. Given the Republican-controlled Congress, there is a strong likelihood that at some point the ACA will be repealed. If and when that occurs, the requirement that healthcare providers provide *more* meaningful access to individuals with LEP will return to the pre-2010 standards (or will be determined by whatever "replacement" option goes into effect). What this means for healthcare providers, as well as the increasingly diverse patients to whom they provide care, remains to be seen. Despite this uncertainty, healthcare providers are strongly cautioned against using the "wait and see" approach. As discussed above, the penalties can be bankrupting.

Ultimately, determining the best option for your organization depends on a variety of factors. The result, however, is the same, and the requirement that you provide meaningful access is not going away. Neither is the risk for failing to do so.

If you have any questions about these suggestions, please contact the author at JWrigley@fisherphillips.com or your Fisher Phillips attorney.

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