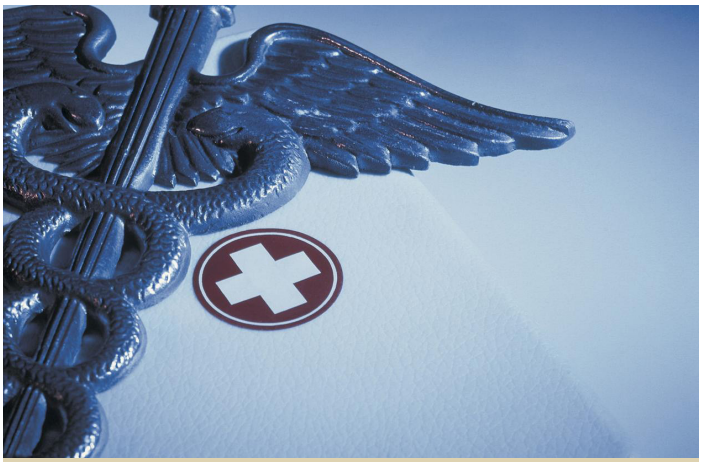

October 2015 • Volume 5, Number 4

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DW HEALTHCARE BLOG
http://www.dwhealthlawblog.com/

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HEALTHCARE **LEGAL**NEWS

HHS'S NEW ANTI-DISCRIMINATION REGULATION PROPOSAL, EXPLAINED

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In September, the Department of Health and Human Services (HHS) released proposed anti-discrimination regulations that, if adopted, change the playing field in which physicians and other healthcare providers practice. These regulations are significant because:

- They apply to all healthcare providers (including providers who do not accept Medicare or Medicaid).
- The sanctions available for violations include possible exclusion from Medicare.
- The regulations change the ability of providers to decline or terminate patients.
- They require providers to incur additional expenses for items that many small providers have not previously been required to possess.

The proposed regulations are the agency's attempt to flesh out the Affordable Care Act's (ACA) mandate prohibiting discrimination "on the basis of race, color, national origin, sex, age or disability" in the provision of services with respect to any health program or activity that receives federal financial assistance. Specifically, the ACA states that healthcare providers cannot discriminate in the provision of healthcare on the basis of any of the following:

- Title VI of the Civil Rights Act of 1964 (Race, color and national origin);
- Title IX of the Education Amendments of 1972 (Sex);
- The Age Discrimination Act of 1975
- Section 794 of Title 29 (Disability).

According to the commentary, the regulations seek to ensure that vital health care services are broadly and nondiscriminatorily available to individuals throughout the country."

The following is intended to describe these changes and what they mean for healthcare providers.

Limited English Proficiency

The most complicated change, and perhaps the one that would require the most from providers, is the requirement to provide

accommodations to people with limited English proficiency, created under the ban on "national origin" discrimination.

Qualified Interpreters All healthcare providers will be required to provide a "qualified interpreter" "in a timely manner" to any person with limited English-speaking ability whom they serve (patients) "or encounter" (anyone else) in administering services. The commentary explains that interpreters are required "when oral communication is a reasonable step to provide meaningful access" to the healthcare system.

Who is a "qualified interpreter"? The regulations define the term "qualified interpreter" very broadly as "an individual who has the characteristics and skills necessary to interpret for an individual with a disability [i.e., American sign language], for an individual with limited English proficiency, or for both." A qualified interpreter must:

1. Be able to interpret "effectively, accurately and impartially … using any necessary specialized vocabulary," and/or
2. Demonstrate proficiency in "and have above average familiarity with speaking and understanding" of both English and the foreign language, "using any necessary specialized vocabulary."

Can anyone be an interpreter? The short answer is "no." The regulations don't require any particular certification to be a qualified interpreter, but the commentary specifically states that merely having an above-average familiarity with a language is not enough.

Can it be an employee? While neither the regulations nor the commentary expressly state that an employee can't be a qualified interpreter, the interpreter must be familiar with and adhere to "generally accepted interpreter ethics principles, including client confidentiality." An example in the commentary states that a bilingual nurse who is competent to speak to the patient in her native language may not be a qualified interpreter "if serving as an interpreter would pose a conflict of interest with the nurse's treatment of the patient."

Can it be a family member? Yes, in some cases. Providers are expressly prohibited from requiring the foreign-language speaker to bring his or her own interpreter (be it a family member or anyone else), but a family member or person accompanying the non-English speaker can serve as an interpreter under the following circumstances:

1. In the case of an emergency situation when no qualified interpreter is immediately available; or
2. If the non-English speaking patient requests that the accompanying adult interpret for him/her, and the accompanying adult agrees to do so.

A child may only be used as an interpreter in "an emergency involving an imminent threat to the safety or welfare" of the person or the public.

If I can't use an employee or a family member, where am I going to find interpreters? An internet-based service, possibly. The commentary states specifically that most entities will, at a minimum, have the capacity to provide qualified interpreters remotely via telephone online service at a "relatively low-cost."

I think I need an interpreter. Simply put, healthcare providers will need to provide the availability of a qualified interpreter, and preferably one not involved in the treatment and care of patients. While, in some cases, it may be a family member that interprets for the patient, providers may not require it, and will have to make arrangements for those who don't bring someone to interpret. HHS suggests that a telephone-based or internet-based service may be a cost-effective option for providers.

Written Notices Providers will also be encouraged, but not required, to post notices "in the most prevalent languages used in a covered entity's service area, as determined by the covered entity." They are required, however, to publish "taglines" in a prevalent language for the provider's area alerting patients to the availability of language services.

But I don't speak Farsi. Neither do I. But HHS states that it will provide sample notices translated in each of the most prevalent languages (Spanish, Chinese, Vietnamese, Korean, Tagalog, Russian, Farsi, French, French Creole, Portuguese, Polish, Japanese, Italian, German and Arabic). The required taglines will be available in these 15 languages electronically, thus, the agency, says, the providers should experience no burden by this requirement.

Gender Identity.

Another area addressed in the regulations is "gender identity," which refers to an individual's "internal sense of gender, which may be different from that individual's sex assigned at birth." The proposed regulations seek to prohibit providers from discriminating against, for example, an individual who is female but prefers to be treated as a male, and vice versa. This, of course, includes transgender people. The agency reasons that this is prohibited under sex discrimination laws, and such discrimination would expose the provider to liability.

Sex Stereotyping.

"Sex stereotyping" involves notions like hairstyle, voice, mannerisms or body characteristics that are stereotypically associated with one gender but not the other. In 1989, the U.S. Supreme Court ruled in Price Waterhouse v. Hopkins that Title VII bars employment discrimination against a person because he or she doesn't act like his sex "should act." This rule would apply the same standard to providing medical care.

Association Discrimination.

"Association discrimination" originated in the Americans With Disabilities Act. It occurs when a person is discriminated against because of the person's association with a disabled person, e.g., an employer refuses to hire a mother because she has a child with special needs. In the regulations, the agency extends "Association discrimination" to association (e.g., friendship, relationship) with any member of a protected class.

What about same-sex discrimination? Interestingly, HHS doesn't include discrimination on the basis of a person's sexual orientation in its definition of sex discrimination. In the commentary, the agency wrote that it supports the prohibition of sexual orientation discrimination, but acknowledged that no federal appellate court has concluded that Title IX's prohibition on discrimination based upon sex applies to discrimination based on sexual orientation. The commentary noted, however, that some district courts "have reached the opposite conclusion." The agency requests comments on whether to extend discrimination based upon sex to include sexual orientation.

Grievance Procedures and Electronic Information Requirements

The proposed regulations would also require all physicians and other providers to take certain administrative steps, including:

- Periodically certifying compliance with the ACA and its regulations;
- Designating at least one employee as a compliance coordinator;
- Adopting grievance procedures that incorporate "appropriate due process standards," and;
- Providing "prompt and equitable" resolution to grievances.

In the commentary, HHS stated that it realizes the potential burden these requirements may impose, and included an exception for instances when compliance results in undue financial burden, administrative burden, or a fundamental alteration of the health program or activity. In such instances, the provider is required to provide information in a format that would ensure, to the maximum extent possible, that disabled patients receive the same information.

Comment Period

HHS is required by federal law to provide the public the opportunity to comment on the proposed regulations. This comment period is a great opportunity for providers to offer their opinion on the regulations and offer some suggestions to the agency, particularly on the practical administration and implementation of compliance programs. The comment period ends on November 9, 2015.

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