Client Alert: Broadened Non-Discrimination Mandates Imposed on Medical Providers – How to Comply

BY PETER J. MARTIN • JULY 29, 2024

The Affordable Care Act, which was signed into law in 2010, contained a provision (commonly referred to as Section 1557) prohibiting discrimination on the basis of race, color, national origin, sex, age or disability in specified health programs or activities, including those that receive Federal financial assistance. Now, after nearly a quarter century of dueling interpretations of the scope of this statutory provision, the Department of Health and Human Services (HHS) has promulgated final regulations that expand the applicability of this statute to encompass any provider receiving Medicare Part B reimbursement, and imposing significant new requirements on such providers.

For example, by **November 2, 2024**, all covered entities must post a Notice of Nondiscrimination that informs patients and the public of their right to not be discriminated against based on a protected characteristic. (The Office for Civil Rights, within HHS, has issued samples of this Notice.) By that same date, covered entities with 15 or more employees must designate a "Section 1557 Coordinator" to, among other things, review complaints about non-compliance with the new rule.

By **July 5, 2025**, all covered entities must also post a Notice of Availability of Language Assistance Services and Auxiliary Aids. By that same date, all covered entities must adopt written policies and procedures to implement a non-discrimination policy, language access procedures, auxiliary aids and services procedures and procedures for reasonable modifications for individuals with disabilities. In addition, covered entities with 15 or more employees must create non-discrimination and civil rights grievance procedures. All covered entities must begin training employees on these policies and procedures no later than **May 1, 2025**, which means those policies and procedures have to be developed in advance of that date so that employees can be trained on them.

Like many HHS regulations, fully understanding them requires review not just of the regulatory text, but of the voluminous commentary accompanying the new rule. For example, the rule's text states that the grievance procedure obligations fall only on covered entities with 15 or more "employees." One would think that covered entities could reasonably assume that in order to evaluate whether they have these additional obligations, they should assess the number of their W-2 employees. However, the regulatory commentary states that: "With respect to the employees who will count towards the 15 or more-employee threshold, OCR will consider the total number of individuals employed by a covered entity. This includes full-time and part-time employees *and independent contractors"* (emphasis added). To add insult to injury, the commentary goes on to justify this interpretation on providers' presumptive future attempts to game the system: "We intend for this clarification to reduce concerns that the 15-employee threshold may lead to questionable employment practices."

Another interpretive hurdle has to do with the ban on discriminating against persons or entities who have a

"relationship or association" with a person within a protected category (e.g., race, color, national origin, sex, age or disability). What "association" means is not explained in the regulation; one has to review extensive case law cited in the regulatory commentary to get a sense of the wide scope of the use of that word in this context. For example, "associational discrimination" appears where an alcohol treatment center is denied a zoning permit because it provided services to disabled persons; where a hearing parent is required to act as an interpreter for a deaf child; and where an employer retaliates against an employee complaining about a supervisor's racist remarks about the employee's family member.

One of the significant challenges posed by the new rule is an obligation on the part of providers to mitigate the risks of discrimination resulting from the use of patient care decision support tools. These tools range from flowcharts and clinical guidelines to complex computer algorithms. By **May 1, 2025**, covered entities must have made reasonable efforts to both determine which such tools use factors that measure race, color, national origin, sex, age of disability and also to mitigate the risk of discrimination resulting from the use of such tools. Surveying a provider's set of tools to assess their use of these factors and then designing steps to mitigate the resultant discrimination risk is a daunting task, particularly for smaller providers who may rely on sophisticated systems purchased from outside vendors. It is to be hoped that these vendors will respond to these new requirements, but it remains the covered entities' responsibility to ensure the identification and mitigation processes are completed by the due date.

Section 1557's twisted path, from enactment in 2010, through dueling regulatory interpretations in 2016 and 2020 under the Obama and Trump Administrations, through an expansion of the definition of sex discrimination to include sexual orientation and gender identity in response to a 2020 Supreme Court decision, has resulted in a final rule with enforcement dates beginning three days before the national election. Although some providers might be tempted to rely upon a change of presidential administration to avoid the new requirements, a more prudent course would be to begin preparations for compliance but remain aware of the political environment. We will continue to monitor the situation and stand ready to assist providers faced with these new challenges.

