

Amid Overwhelming Opposition, HHS Issues Final Provider Conscience Rule

On December 19, 2008, HHS published the final “provider conscience” regulation in the Federal Register, 73 Fed. Reg. 78072 et seq. This rule prohibits discrimination or retaliation against certain federally-funded individual and organizational providers (including health centers), as well as employees/volunteers/contractors/trainees who work for such organizations, who refuse to perform or to assist in the performance of health care services which they find religiously or morally objectionable. Despite overwhelming opposition from various individuals and organizations (including NACHC), HHS adopted the rule as it was proposed last August, with the exception of certain changes to the written certification requirements. Since the final publication last month, several stakeholders (including members of Congress and various associations representing providers) have requested that the new Administration overturn the rule. At the present time, however, the new rule will become effective on January 20, 2009. This Alert summarizes the new rule and its potential impact on health centers and their patients.

Presently, there are several statutes on the books that protect the “conscience rights” of health care providers. Generally, such statutes protect from discrimination individual and institutional providers that refuse to perform, receive training in, and/or provide referrals or make arrangements for abortion (and in some cases sterilization) services based on religious beliefs. Throughout the preamble to the new rule, HHS insists that it is consistent with these existing laws, merely codifying what is already in effect.

However, as NACHC noted in its comments on the proposed rule, the rule goes well beyond its stated scope and purpose, not only codifying but also expanding current law. In particular, it broadly protects all health care staff (clinicians and non-clinical support staff) from being required to perform or assist in the performance of any service or activity related to the provision of health care services regardless of how attenuated the connection (or from reprisals based on refusal to do the same) if such service or activity is contrary to the individual’s religious beliefs or moral convictions. The rule does not limit the services to which this protection applies, nor does it limit the individuals (*i.e.*, clinical versus non-clinical) who are protected. Further, the rule prohibits discrimination against any health care provider in the employment, promotion, termination or extension of staff privileges because he or she performed or assisted in the performance, or refused to perform or assist in the performance, of a lawful sterilization procedure or abortion because of his or her religious beliefs or moral convictions.

In our comments, NACHC strongly urged HHS to withdraw the proposed rule in its entirety, based both on the overall damage it could cause to access to care for medically underserved populations, as well as the specific harm to health centers that serve as the principle (and, often, sole) providers to such populations.

The New Rule is Contrary to and Conflicts with Section 330-Related Services Obligations

NACHC believes the rule is contrary to and conflicts with health centers’ service obligations required under Section 330 (and some state laws). Consequently, we believe the rule places

health centers in a position under which they may be unable to comply with both the rule and their Section 330-related obligations, possibly exposing health centers to penalty, sanction and/or jeopardizing of their grants regardless of which actions they take. As noted above, the new rule broadly prohibits health centers from requiring employees to perform or assist in the performance of any health care-related service or activity if such service or activity would be contrary to his religious beliefs or moral convictions. This prohibition does not explicitly restrict health centers from providing Section 330-required services (including voluntary family planning services and immunizations) as well as other services which they are “ethically” bound to provide (*e.g.*, treatments for STDs, HIV/AIDs and other chronic conditions). However, health centers may be unable to meet their service obligations effectively if health care personnel and support staff are allowed to “opt-out” of performing services which they find objectionable.

Compounding this problem is the broad definition in the rule of the term “assist in the performance,” which refers to participation in any activity with a reasonable connection to health services, including counseling, referral, training, and making other arrangements for the services. Since “assist in the performance” is defined to include various forms of patient assistance, health centers may not only be limited in furnishing required and other necessary clinical services, but may also be limited in providing services which support patient access to care. Further, the rule does not define terms such as “moral conviction,” “abortion” and “sterilization,” consequently, health centers are somewhat at a loss to know if they are operating in compliance with the rule.

Patient access – either direct or by referral – to virtually any service provided by any health center staff (paid and non-paid) may be impacted by the rule. Examples include providers who refuse to treat sexually transmitted diseases and/or provide family planning services, including birth control; staff that refuse to furnish appropriate referrals to other providers for services which the staff will not provide directly; pharmacists who refuse to fill prescriptions for HIV/AIDs; front desk staff who refuse to schedule appointments for services to which they object and/or for undocumented patients. Further, not only could providers limit or restrict the provision of services, they also could justify a refusal to inform or counsel patients regarding available options, thus affecting the ability of patients to make informed decisions regarding their health care.

As noted above, in its comments NACHC urged HHS to withdraw the rule in its entirety. However, short of a complete withdrawal NACHC requested that HHS specifically exempt health centers from its application to ensure that centers can continue to serve and provide essential access to care to their medically underserved populations free from fear of penalty, sanction or jeopardizing of Section 330 grant funds. Alternatively, NACHC requested that HHS:

- Clarify that the rule will apply only to the extent that it is not contrary to and does not conflict with requirements of the HHS program for which the affected entity receives federal funds.
- Modify the definition of “assist in the performance” to clarify that it applies solely to assistance furnished during the actual provision of clinical services, thus excluding

support services that facilitate patient access to care (*e.g.*, such as case management, referrals, registration and intake, counseling, *etc.*).

- Clarify the scope of “lawful sterilization procedure or abortion” to ensure that it does not impede the provision of lawful counseling/referral activities as well as certain services related to sterilization (*e.g.*, tubal ligations and vasectomies) and/or reproductive and contraceptive services (including emergency contraceptive services in cases of rape and incest).
- Add parameters/guidelines regarding what would and would not constitute instances of “moral conviction” to ensure that individuals cannot unjustifiably claim it as grounds to not perform or assist with a service that the individual simply does not want to provide.

HHS rejected each of these recommendations. In addressing concerns that the rule is inconsistent with requirements for certain funded programs, HHS stated that it does not operate its programs in conflict with the existing federal statutory protections which are implemented by this rule and, as such, the “Department believes that many commenters are confused as to the programmatic requirements of various departmental programs and suggests that concerned parties seek clarification from individual program offices as appropriate.”

With respect to the definition of “assist in performance,” HHS states that the term applies to participation in any activity with a reasonable connection to the objectionable procedure, including referrals, training, and other arrangements for the service, but does not define “reasonable.” Further, HHS rejected out of hand suggestions to: (1) require providers to furnish **referrals** for services they find morally objectionable; and (2) define or include parameters for the term “moral conviction” (stating that the common definitions are plainly understood and, as such, the agency will apply common sense interpretations).

The New Rule Jeopardizes Access to Care for Underserved Populations

NACHC believes that the new rule jeopardizes overall access to, and availability of, essential health care services for medically-underserved populations and areas by limiting the ability of health centers to: (1) provide the clinical and non-clinical services required by Section 330 (as well as other services appropriate for the needs of their populations); and (2) maintain the core staff of providers and support personnel necessary to furnish the services by prohibiting employment discrimination based solely on performance of or refusal to perform certain services. Further, in limiting access, the rule does so in a manner that disproportionately impacts the poorest and most vulnerable populations, thus generally undermining the health care safety-net.

In the preamble, HHS disputes NACHC’s (and others) comments in this regard, but does not provide much of a basis to support its position. Ironically, it points to its “expansion of the federal Community Health Center program” as an example of its initiatives over the years to increase access to care for underserved populations.

Next Steps

NACHC will monitor closely and report back any future actions by Congress, the incoming Administration, and other stakeholders to overturn or revise this new rule. In the meantime, **NACHC intends to open a dialogue with HRSA, urging it to develop and communicate clear, definitive guidance for health centers on how they can reconcile potential inconsistencies between this rule and Section 330-related requirements, thus avoiding any penalties, sanctions, or jeopardy to their Section 330 grant funds.**

For additional information on the new rule and its application to health centers, please contact either Roger Schwartz (RSchwartz@NACHC.com or 202-293-0158) or Susan Walter (SWalter@NACHC.com or 202-296-1890).