LOG Surgery Center

Summary of Affordable Care Act Section 1557 Final Rule

Section 1557 of the Affordable Care Act (Section 1557) prohibits discrimination on the basis of race, color, national origin, age, disability, or sex in a health care program or activity, any part of which receives Federal financial assistance. (42 U.S.C. § 18116). On April 26, 2024, the U.S. Department of Health and Human Services (HHS) issued a Final Rule amending the Section 1557 regulations (45 C.F.R. Part 92) to enhance these protections. The Final Rule is effective on July 5, 2024, with subsequent staggered effective dates for certain requirements (see chart at the end of this document). The Rule applies to every health program or activity, any part of which receives Federal financial assistance, directly or indirectly, from HHS.[1] The Final Rule and the Section 1557 regulations generally do not apply to an employer with regard to its employment practices. The Final Rule is summarized below

1. **Administrative Obligations**.

    a. Section 1557 Coordinator (§ 92.7). Entities that are subject to the Final Rule (hereinafter, "covered entities") must designate a Section 1557 coordinator to oversee compliance with Section 1557 requirements. This individual is responsible for (among other things) processing grievances, ensuring compliance with recordkeeping requirements, implementing language-access procedures, and coordinating training.

    b. Policies and Procedures (§ 92.8). Covered entities must implement written policies and procedures, which **must include an effective date** and be reasonably designed, considering the size, complexity, and the type of health programs or activities undertaken by the covered entity. Policies and procedures must specifically include a **nondiscrimination** policy**, grievance** procedures**, language access** procedures**, effective communication** procedures, and **reasonable modification** procedures**.**

    c. Training (§ 92.9). The covered entity must train employees on its policies and procedures no later than 30 days following implementation of the policies and procedures and within a reasonable time following any material change. Training must be documented and such documentation retained for no less than 3 years. For new employees, training must be provided "within a reasonable time" after the employee joins the covered entity's workforce.

    d. Required Notices. Covered entities must provide the following notices:
        i. Notice of Nondiscrimination (§ 92.10). Covered entities must annually and upon request provide a notice of nondiscrimination to participants,

[1] The Final Rule also applies to programs and activities administered by State Exchanges and Federally-facilitated Exchanges and contains provisions applicable to those entities, which are not addressed here.

beneficiaries, enrollees and applicants of health programs and activities. The Notice must be publicly available and must contain the elements set forth in the regulations. The public version must be in a *sand serif* font, at least 20-point font, and posted in a physical location that is accessible to individuals who may have low vision.

ii. Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (§ 92.11). Covered entities must annually and upon request provide notice regarding availability of free language assistance services and auxiliary aids and services to participants, beneficiaries, enrollees and applicants of health programs and activities. This Notice must be provided in English and at least the 15 most commonly spoken languages in the State and must be provided in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.

This Notice must be publicly posted ***and*** must accompany the following electronic and written communications:

1. Notice of nondiscrimination required under 45 CFR § 92.10
2. HIPAA Notice of Privacy Practices
3. Application and intake forms
4. Notices of denial or termination of eligibility, benefits or services, and notices of appeal and grievance rights
5. Communications related to an individual's rights, eligibility, benefits or services that require a response from a participant, beneficiary, enrollee or applicant
6. Communications related to a public health emergency
7. Consent forms and instructions related to medical procedures or operations, medical powers of attorney, or living wills
8. Discharge papers
9. Communications related to the cost and payment of care, including medical billing and collections materials and good-faith estimates
10. Complaint forms
11. Patient handbooks

2. **Substantive Provisions**.

a. Meaningful access for individuals with Limited English Proficiency (LEP) (§ 92.201). Covered entities must provide to each individual with LEP – including companions with LEP – language assistance services that are free of charge, accurate and timely, and protect the privacy and independent decision-making ability of the individual

with LEP. The Final Rule includes specific requirements for interpreter and translation services.

b. Effective communication for individuals with disabilities (§ 92.202). A covered entity must:

    i. Take appropriate steps to ensure that communications with individuals with disabilities (including companions with disabilities), are as effective as communications with non-disabled individuals in its health programs and activities, in accordance with the standards found at 28 CFR §§ 35.130 and 35.160 through 35.164; and

    ii. Provide appropriate auxiliary aids and services where necessary to afford individuals with disabilities an equal opportunity to participate in, and enjoy the benefits of, the health program or activity in question. Such auxiliary aids and services must be provided free of charge, in accessible formats, in a timely manner, and in such a way to protect the privacy and the independence of the individual with a disability.

c. Nondiscrimination in the use of patient care decision support tools. The Final Rule expressly prohibits discrimination on the basis of race, color, national origin, sex, age or disability in the use of "patient care decision support tools," defined to mean "any automated or non-automated tool, mechanism, method, technology, or combination thereof used by a covered entity to support clinical decision-making in its health programs and activities."

    i. Examples of patient care decision support tools include: flowcharts; formulas; equations; calculators; algorithms; utilization management applications; software as medical devices; software in medical devices; screening, risk assessment, and eligibility tools; and diagnostic and treatment guidance tools.

    ii. Examples of items that are NOT patient care decision support tools include: automated and non-automated tools that covered entities use for administrative and billing-related activities; automated medical coding; fraud, waste and abuse; patient scheduling; facilities management; inventory and materials management; supply chain management; financial market investment management; or employment and staffing-related activities.

    iii. The Final Rule imposes on covered entities an ongoing duty to make reasonable efforts to identify uses of patient care decision support tools that

employ input variables or factors that measure race, color, national origin, sex, age, or disability.

iv. For each such patient care decision support tool, the covered entity must make reasonable efforts to mitigate the risk of discrimination resulting from the tool's use in its health programs or activities.

d. Nondiscrimination in the delivery of health programs and activities through telehealth. The Final Rule expressly prohibits covered entities from discriminating on the basis of race, color, national origin, sex, age or disability in delivery of its health programs and activities through telehealth services.

3. **Miscellaneous**. In addition, the Final Rule:

a. Addresses accessibility of information and communication technology for individuals with disabilities; accessibility for buildings and facilities; requirements to make reasonable modifications; and equal program access on the basis of sex.

b. Provides that Medicare Part B payments constitute a form of Federal financial assistance for purposes of Section 1557 and other federal civil rights laws. HHS historically has taken the position that Medicare Part B funding is not "federal financial assistance" for purposes of Section 1557.

c. Codifies that Section 1557's prohibition against discrimination based on sex includes pregnancy, sexual orientation, gender identity and sex characteristics, consistent with the U.S. Supreme Court's decision in *Bostock v. Clayton County*.

d. Preempts state laws that prohibit gender-affirming procedures.

e. Establishes an exemption process whereby covered entities may (but are not required to) obtain formal assurance from OCR that they are entitled to an exemption pursuant to the protections in religious freedom and conscience laws when denying services to patients based on their beliefs.

4. **Compliance Deadlines**. As noted above, the Final Rule is effective on July 5, 2024, but certain sections of the Final Rule have subsequent staggered effective dates as follows:

Section 1557 requirement	Compliance Date
§ 92.7 (Designate a Section 1557 Coordinator)	November 4, 2024

§ 92.8 (Policies and procedures)	July 7, 2025
§ 92.9 (Training)	As soon as possible following implementation of the policies and procedures required by § 92.8, and no later May 1, 2025
§ 92.10 (Notice of nondiscrimination)	November 4, 2024
§ 92.11 (Notice of availability of language assistance services and auxiliary aids and services)	July 7, 2025
§ 99.210(b) and (c) (Nondiscrimination in the use of patient care decision support tools)	May 1, 2025