HHS Finalizes Section 1557 Nondiscrimination Rule - Impacts for RHCs Q&A Follow-Up

RHCs should first view the recording of this presentation here. This document serves as a resource for the questions that were not able to be answered live or needed additional information!

Resources

- Finalized Regulation
- HHS/Office of Civil Rights FAQs
- Sample Nondiscrimination Notice
- Example Grievance Procedure
- Sample Language Access Procedures
- Sample Effective Communication Procedure
- Sample Notice of Availability – if you need a translation that is not available here, please contact (800) 368-1019.
- Top 15 Non-English Languages by State – this is a 2017 document, but it is the most updated version that is available.

General Applicability

Q: Do these regulations apply to hospitals as well?

A: Yes, all health care facilities that accept Medicare, Medicaid, etc. are subject to these requirements.

Q: This also applies to Indian Health Services (IHS) too, I assume?

A: Yes, as the rule applies to all health programs/activities that receive funding from HHS, as well as health programs administered by HHS, and the health insurance Marketplace "and all plans offered by issuers that participate in those Marketplaces that receive Federal financial assistance."

Nondiscrimination Policies / Section 1557 Coordinator

Q: If an RHC is owned by a hospital/system, does the RHC need to have their own set of policies and procedures? Similarly, does the individual clinic need to have their own Section 1557 Coordinator?

A: HHS/OCR states that "in order to provide covered entities with flexibility, OCR clarifies that large health systems may customize their Coordinator and designee configurations as long as each individual covered entity has either a Coordinator or designee responsible for section 1557 compliance."

NARHC interpretation: you can have one overarching Section 1557 coordinator, but each site should have an individual (designee) able to handle individual needs of the facility and facilitate communication with the Section 1557 coordinator. If you have a policy to cover your entire system, ensure that it is very explicit as to the entities it covers and any differences between each facility.

Q: Do we have to name the position '1557 Coordinator' or can we use the Compliance Officer?

A: It seems as if there can be some variability in what this individual is titled, as an example HHS/OCR calls them a "Civil Rights Coordinator" on the sample notice of discrimination. The element more important than the title, however, is that the individual's contact information is listed in required locations and that members of staff know who that designated individual who will be handling compliance of this rule is.

Q: On posting the contact information for the coordinator, would an email suffice?

A: The rule requires that "current contact information" be posted but does not stipulate what that includes. The individual's name is **not** required.

Notice of Nondiscrimination

Q: When it states that the notice must be provided annually – is a posted notice sufficient?

A: The **Notice of Nondiscrimination** (longer notice, in English), must be posted (sans serif/20-point font) and provided annually to patients and upon request. There is not an opt-out option for patients to not receive this.

Q: What if patients do not want the notices?

A: Similar to GFE policies, we understand that not all patients may understand or want the notices/estimates that they're receiving, however there is not an opt-out option for the Notice of Nondiscrimination that is required to be provided annually.

Q: Would we be required to document in the medical record that the patient received the Notice of Nondiscrimination? How do we prove that we're compliant with this requirement? Is a signed acknowledgement necessary?

A: While HHS/OCR does not explicitly say this, it is likely a best practice to document in some way that the patient received the notices.

Notice of Availability

Q: When does this notice need to be provided to patients?

A: The **Notice of Availability** (shorter notice in English + 15 most common languages in your state) must be posted wherever the Notice of Nondiscrimination is posted, as well as included on the following list of documents/communications.

- the notice of privacy practices required by the implementing regulations for the Health Insurance Portability and Accountability Act;
- application and intake forms;
- notices of denial or termination of eligibility, benefits, or services, including Explanations of Benefits (EOBs), and notices of appeal and grievance rights;
- communications related to a person's rights, eligibility, benefits, or services that require or request a response from a participant, beneficiary, enrollee, or applicant;
- communications related to a public health emergency;
- consent forms and instructions related to medical procedures or operations, medical power of attorney, or living will (with an option of providing only one notice for all documents bundled together);
- discharge papers;
- complaint forms;
- patient and member handbooks;
- communications related to the cost and payment of care with respect to an individual, including medical billing and collections materials, and good faith estimates.

Q: Can patients opt out of receiving these notices?

A: On an annual basis, HHS/OCR does allow patients to "opt out" of receiving the Notice of Availability. Furthermore, covered entities are allowed to document a patient's primary language and provide the Notice of Availability only in that language for the year. If a patient opts out, this should be documented somewhere in the patient record.

<u>In-House Interpreters and Interpretation Services</u>

Q: Do we have to list specific names [of bilingual staff members and/or in-house interpreters]? Can we use job titles instead?

A: The rule does require that if you employ qualified bilingual/multilingual staff members, their *names* be included in various locations of your policies and procedures. We recognize that these individuals may change and that may require an update to your P&Ps, but the rule is specific to names and not simply job titles or contact information.

Q: For our in-house interpreters do they need to be certified interpreters? Certified by whom?

A: The rule uses the term "qualified" and not certified. The rule defines these individuals as the following:

> *"Qualified bilingual/multilingual staff* means a member of a covered entity's workforce who is designated by the covered entity to provide in-language oral language assistance as part of the person's current, assigned job responsibilities and who has demonstrated to the covered entity that they are:

(1) Proficient in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology and phraseology; and

(2) Able to effectively, accurately, and impartially communicate directly with individuals with limited English proficiency in their primary languages."

Q: If our facility does not have bilingual/multilingual staff members, can we use electronic interpretation services?

A: Yes! The rule specifies that language assistance services can be provided in-person or remotely or through written translation by a qualified translator. Your language access procedures would specify how to access whichever translation method you utilize when needed.

Telehealth / Patient Care Decision Support Tools

Q: We are a very small rural facility and don't have sufficient patient volume to perform a credible review of care decision support tools. Could we request the company's nondiscrimination notice and use that as a verification?

A: Covered entities must take steps to "identify and mitigate discrimination when they use patient care decision support tools," if you are utilizing artificial intelligence or other clinical algorithms at your RHC. Providers will have an ongoing responsibility to ensure that if they use patient care decision support tools, then providers must ensure that those tools do not yield discriminatory care. Covered entities should have a policy in place to mitigate the risk of discrimination from the use of AI and other patient care support tools. HHS/OCR recognizes that every facility has a different capacity to do this, and they will take this into account in determining compliance. It seems like best practice to follow the vendor's nondiscrimination notice.

Q: Was there anything more specific for telehealth nondiscrimination? Or is a policy in place that mentions it be sufficient?

A: The rule isn't super specific on this. It mainly requires you have a policy in place to demonstrate that you have considered how patients with limited English proficiency, or with disabilities might interface with your telehealth offerings.

RHC ADA Requirements

Q: How is this different from ADA requirements that RHCs are not subject to?

A: NARHC is unaware of any RHC specific exemption to ADA requirements, and part of the Section 1557 rule requires that covered entities (including RHCs) may not discriminate on the basis of disability. This means that the facility must make reasonable accommodations, modifications to policies and procedures, etc. to serve patients with disabilities.

Facilities don't need to make significant changes that "fundamentally alter" their services or result in an "undue burden." Typically, new construction/alterations must also follow ADA accessibility standards.

These resources are prepared with the most available and updated information, and NARHC's interpretation of the regulation, as of August 2024 and are subject to change. If your question was clinic-specific and not addressed here, or you need any further information please contact Sarah.Hohman@narhc.org.