Final Rule on Nondiscrimination in Health Programs and Activities

Member Impact Summary & Table

The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) and the Centers for Medicare and Medicaid Services (CMS) issued a final rule under Section 1557 of the Affordable Care Act (ACA), advancing protections against discrimination in health care. The purpose of the rule, entitled "Nondiscrimination in Health Programs and Activities," is to restore protections against discrimination on the basis of race, color, national origin, sex, age, and disability. The rule also reduces language access barriers, expands physical and digital accessibility, and tackles bias in health technology.

The final rule closely follows the proposed rule issued in July 2022 and, in many ways, reverses the Section 1557 rule issued by the Trump Administration in June 2020, which was a significant departure from the Obama Administration's original Section 1557 rule issued in 2016.

This rule applies to covered entities, which, per HHS' definition, includes any health program or activity receiving federal funds from HHS, any program or activity administered under Title I of the ACA, and health insurance marketplace participants that have received Federal financial assistance. This means that nursing homes, ID/DD providers, and Medicare Advantage plans are subject to this Final Rule. Assisted living facilities could also be subject to the rule if they receive Federal financial assistance (e.g., through a Medicaid waiver program).

Summary of Regulatory Changes:
HHS promulgated 45 CFR Part 92 to provide for the enforcement of Section 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. 18116 (commonly known as Section 1557). This final rule replaces the existing regulatory requirements of Part 92 by:

- Adding new requirements under Subpart A,
- Adding a new Subpart B that includes the specific discrimination prohibition of the rule,
- Converting the former Subpart B to Subpart C and adding new provisions therein, and
- Moving the enforcement mechanisms and procedures, including the religious and conscience exemptions, to a new Subpart D.

The rule also expands on existing language and adds new definitions to clarify the intent and purpose of several requirements. The table below covers the relevant new sections of the rule that require action by providers, along with tips for operational compliance and the implementation dates. Not included in the table are sections of the rule that do not require action by providers. The final rule also establishes new requirements for health insurers and health plans at Parts 147, 155, and 156. The effective date of the rule is July 5, 2024.

The final rule and FAQs are linked below:

- Nondiscrimination in Health Programs and Activities Final Rule
- 1557 Regulations FAQs

Regulatory Summary

The table below provides the relevant sections of the regulation, along with an explanation of the regulation and any available resources, and the date by which the regulatory section must be implemented.

Section 1557 Requirement and Provision	Regulatory Language	Explanation and Resources	Implementation Timeline *(Actual date)*
Subpart A **§ 92.7 Section 1557 Coordinator**	(a) **Section 1557 Coordinator and designees.** A covered entity that employs fifteen or more persons must designate and authorize at least one employee, a "Section 1557 Coordinator," to coordinate the covered entity's compliance with its responsibilities under section 1557 and this part in its health programs and activities, including the investigation of any grievance communicated to it alleging noncompliance with section 1557 or this part or alleging any action that would be prohibited by section 1557 or this part. As appropriate, a covered entity may assign one or more designees to carry out some of these responsibilities, but the Section 1557 Coordinator must retain ultimate oversight for ensuring coordination with the covered entity's compliance with this part. (b) **Responsibilities of Section 1557 Coordinator**. A covered entity must ensure that, at minimum, the Section 1557 Coordinator: (1) Receives, reviews, and processes grievances, filed under the grievance procedure as set forth in § 92.8(c); (2) Coordinates the covered entity's recordkeeping requirements as set forth in § 92.8(c); (3) Coordinates effective implementation of the covered entity's language access procedures as set forth in § 92.8(d);	Providers must designate one (or more) employee as a "Section 1557 coordinator." This individual must be responsible for the following: • Grievance process (see 92.8(c)) • Recordkeeping (see 92.8(c)) • Language access procedures (see 92.8(d)) • Effective communication procedures (see 92.8(e)) • Reasonable modification procedures (see 92.8(f)) • Employee training and documentation (see 92.9) The Section 1557 coordinator should familiarize themselves with the regulations outlined here. If multiple employees are designated, one must be designated as lead.	Within 120 days of effective date **November 2, 2024**

	(4) Coordinates effective implementation of the covered entity's effective communication procedures as set forth in § 92.8(e); (5) Coordinates effective implementation of the covered entity's reasonable modification procedures as set forth in § 92.8(f); and (6) Coordinates training of relevant employees as set forth in § 92.9, including maintaining documentation required by such section.		
Subpart A **§ 92.8 Policies and Procedures**	(a) **General requirement.** A covered entity must implement written policies and procedures in its health programs and activities that are designed to comply with the requirements of this part. The policies and procedures must include an effective date and be reasonably designed, taking into account the size, complexity, and the type of health programs or activities undertaken by a covered entity, to ensure compliance with this part. (**b) Nondiscrimination policy.** (1) A covered entity must implement a written policy in its health programs and activities that, at minimum, states the covered entity does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), sex (consistent with the scope of sex discrimination described at § 92.101(a)(2)), age, or disability; that the covered entity provides language assistance services and appropriate auxiliary aids and services free of charge, when necessary for compliance with section 1557 or this part; that the covered entity will provide reasonable modifications for individuals with disabilities; and that provides the current contact information for the Section 1557 Coordinator required by § 92.7 (if applicable). (2) OCR considers it a best practice toward achieving compliance for a covered entity to provide information that it has been granted a temporary exemption or granted an assurance of exemption under § 92.302(b)	Providers must develop written policies and procedures (P&P) to comply with the requirements. These new policies and procedures may be incorporated into existing P&P related to anti-discrimination. At a minimum, the P&P must include: • Nondiscrimination policy ○ Free template (HHS) • Written grievance procedures (for any provider with 15+ employees) ○ Records must be retained for three calendar years from the date the grievance was resolved ○ Record must include: ▪ Grievance ▪ Name and contact info of the complainant ▪ Alleged discriminatory action and basis(es) of discrimination ▪ Date the grievance was filed ▪ Date the grievance was resolved ▪ Grievance resolution ▪ Oher pertinent information ○ Records must be confidential ○ Written Grievance Procedure Example (HHS)	Within one year of effective date. **July 5, 2025**

	in the nondiscrimination policy required by paragraph (b)(1) of this section. **(c) Grievance procedures.** (1) A covered entity that employs fifteen or more persons must implement written grievance procedures in its health programs and activities that provide for the prompt and equitable resolution of grievances alleging any action that would be prohibited by section 1557 or this part. (2) A covered entity to which this paragraph applies must retain records related to grievances filed pursuant to the covered entity's grievance procedures required under paragraph (c)(1) of this section that allege discrimination on the basis of race, color, national origin, sex, age, or disability for no less than three (3) calendar years from the date the covered entity resolves the grievance. The records must include the grievance; the name and contact information of the complainant (if provided by complainant); the alleged discriminatory action and alleged basis (or bases) of discrimination; the date the grievance was filed; the date the grievance was resolved; grievance resolution; and any other pertinent information. (3) A covered entity to which this paragraph (c) applies must keep confidential the identity of an individual who has filed a grievance under this part except as required by law or to the extent necessary to carry out the purposes of this part, including the conduct of any investigation. **(d) Language access procedures.** A covered entity must implement written language access procedures in its health programs and activities describing the covered entity's process for providing language assistance services to individuals with limited English proficiency when required under § 92.201. At a minimum, the language access procedures must include current contact information for the	• Written language access procedures ○ Describe process for providing language services (see 92.201 for details) ○ Language access procedures must include: ▪ Contact info for Section 1557 Coordinator (if applicable) ▪ How staff identifies a resident with limited English proficiency ▪ How staff obtain services of interpreters or translators to communicate ▪ Names of qualified bilingual staff ▪ List of electronic and written translated materials the organization has, what languages they are available in, their date of issuance and how to access electronic translations • Written communication procedures ○ Describe process for ensuring effective communication with individuals with disabilities (see 92.202 for details) ○ Communication procedures must include: ▪ Contact information for Section 1557 coordinator (if applicable) ▪ How to obtain services of qualified interpreter ▪ Names of qualified interpreter staff members ▪ How to access auxiliary aides and services* • Written procedures describing policies to make "reasonable" modifications to policies, practices or procedures to avoid discrimination on basis of disability. This	

	section 1557 Coordinator (if applicable); how an employee identifies whether an individual has limited English proficiency; how an employee obtains the services of qualified interpreters and translators the covered entity uses to communicate with an individual with limited English proficiency; the names of any qualified bilingual staff members; and a list of any electronic and written translated materials the covered entity has, the languages they are translated into, date of issuance, and how to access electronic translations. **(e) Effective communication procedures.** A covered entity must implement written effective communication procedures in its health programs and activities describing the covered entity's process for ensuring effective communication for individuals with disabilities when required under § 92.202. At a minimum, a covered entity's effective communication procedures must include current contact information for the Section 1557 Coordinator (if applicable); how an employee obtains the services of qualified interpreters the covered entity uses to communicate with individuals with disabilities, including the names of any qualified interpreter staff members; and how to access appropriate auxiliary aids and services. **(f) Reasonable modification procedures**. A covered entity must implement written procedures in its health programs and activities describing the covered entity's process for making reasonable modifications to its policies, practices, or procedures when necessary to avoid discrimination on the basis of disability as required under § 92.205. At a minimum, the reasonable modification procedures must include current contact information for the covered entity's Section 1557 Coordinator (if applicable); a description of the covered entity's process for responding to requests from individuals with disabilities for changes, exceptions, or adjustments to a rule, policy, practice, or service of the covered entity; and a process for determining whether making the modification	must include: ○ Contact information Section 1557 Coordinator (if applicable) ○ Description of the covered entity's process for responding to requests from individuals with disabilities for changes, exceptions, or adjustments to a rule, policy, practice, or service of the covered entity; ○ Process for determining whether making the modification would fundamentally alter the nature of the health program or activity, including identifying an alternative modification that does not result in a fundamental alteration to ensure the individual with a disability receives the benefits or services in question. *The final rule provides the following definition of auxiliary aids and services: ***Auxiliary aids and services include, for example:*** *(1)* ***Qualified interpreters*** *on-site or through video remote interpreting (VRI) services, as defined in 28 CFR 35.104 and 36.104; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunications products and systems, including text telephones (TTYs), videophones, and captioned telephones, or equally effective telecommunications devices; videotext displays; accessible information and*	

	would fundamentally alter the nature of the health program or activity, including identifying an alternative modification that does not result in a fundamental alteration to ensure the individual with a disability receives the benefits or services in question. **(g) Combined policies and procedures.** A covered entity may combine the content of the policies and procedures required by paragraphs (b) through (f) of this section with any policies and procedures pursuant to title VI, section 504, title IX, and the Age Act if section 1557 and the provisions in this part are clearly addressed therein. **(h) Changes to policies and procedures.** (1) Covered entities must review and revise the policies and procedures required by paragraphs (b) through (g) of this section, as necessary, to ensure they are current and in compliance with section 1557 and this part; and (2) A covered entity may change a policy or procedure required by paragraphs (b) through (g) of this section at any time, provided that such changes comply with section 1557 and this part.	*communication technology (ICT); or other effective methods of making aurally delivered information available to persons who are deaf or hard of hearing;* *(2) **Qualified readers**; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs (SAP); large print materials; accessible information and communication technology; or other effective methods of making visually delivered materials available to persons who are blind or have low vision;* *(3) **Acquisition or modification of equipment and devices**; and* *(4) **Other similar services and actions**.*	
Subpart A **§ 92.9 Training**	(a) A covered entity must train relevant employees of its health programs and activities on the civil rights policies and procedures required by § 92.8, as necessary and appropriate for the employees to carry out their functions within the covered entity consistent with the requirements of this part. (b) A covered entity must provide training that meets the requirements of paragraph (a) of this section, as follows: (1) To each relevant employee of the health program or activity as soon as possible, but no later than 30 days following a covered entity's implementation of the policies and procedures required by § 92.8, and no later than 300 days following **July 5, 2024** (2) Thereafter, to each new relevant employee of the	Providers must train **existing** relevant employees* on P&P developed above, no later than 30 days once they are implemented, and no later than May 1, 2025. For each new staff, they must be trained on these P&P within a "reasonable" period of time after hire. Providers should consider incorporating this training into their new hire employee training. Training must be documented and retained for three years.	Following a covered entity's implementation of the policies and procedures required by § 92.8, and no later than one year of effective date. **July 5, 2025**

	health program or activity within a reasonable period of time after the employee joins the covered entity's workforce; and (3) To each relevant employee of the health program or activity whose functions are affected by a material change in the policies or procedures required by § 92.8 and any other civil rights policies or procedures the covered entity has implemented within a reasonable period of time after the material change has been made. (4) For purposes of this section, "relevant employees" includes permanent and temporary employees whose roles and responsibilities entail interacting with patients and members of the public; making decisions that directly or indirectly affect patients' health care, including the covered entity's executive leadership team and legal counsel; and performing tasks and making decisions that directly or indirectly affect patients' financial obligations, including billing and collections. (c) A covered entity must contemporaneously document its employees' completion of the training required by paragraphs (a) and (b) of this section in written or electronic form and retain said documentation for no less than three (3) calendar years.	*The final rule provides the following definition of "relevant employee" *Relevant employees includes permanent and temporary employees whose roles and responsibilities entail interacting with patients and members of the public; making decisions that directly or indirectly affect patients' health care, including the covered entity's executive leadership team and legal counsel; and performing tasks and making decisions that directly or indirectly affect patients' financial obligations, including billing and collections.*	
Subpart A § 92.10 Notice of nondiscrimination	(a) A covered entity must provide a notice of nondiscrimination to participants, beneficiaries, enrollees, and applicants of its health programs and activities, and members of the public. (1) The notice required under this paragraph (a) must include the following information relating to the covered entity's health programs and activities: (i) The covered entity does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), sex (consistent with the scope of sex discrimination described at § 92.101(a)(2)), age,	Providers must provide a nondiscrimination notice to residents, representatives and staff. The notice must include: • Non-discrimination policy • Reasonable modifications for individuals with disabilities • Provision of language assistance services for individuals with disabilities and individuals with limited English proficiency • How to obtain modifications, such as auxiliary aids and services	Within 120 days of effective date. **November 02, 2024**

	or disability; (ii) The covered entity provides reasonable modifications for individuals with disabilities, and appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, such as braille or large print, free of charge and in a timely manner, when such modifications, aids, and services are necessary to ensure accessibility and an equal opportunity to participate to individuals with disabilities; (iii) The covered entity provides language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, when such services are a reasonable step to provide meaningful access to an individual with limited English proficiency; (iv) How to obtain from the covered entity the reasonable modifications, appropriate auxiliary aids and services, and language assistance services in paragraphs (a)(1)(ii) and (iii) of this section; (v) The contact information for the covered entity's Section 1557 Coordinator designated pursuant to § 92.7 (if applicable); (vi) The availability of the covered entity's grievance procedure pursuant to § 92.8(c) and how to file a grievance (if applicable); (vii) Details on how to file a discrimination complaint with OCR in the Department; and (viii) How to access the covered entity's website, if it has one, that provides the information required under this paragraph (a)(1). (2) The notice required under this paragraph (a) must be provided in a covered entity's health program or activity, as follows: (i) On an annual basis to participants,	• Section 1557 coordinator contact info (if applicable) • Grievance procedure and how to file • How to file a discrimination complaint with OCR • How to access information on the organization's website (if applicable) The notice must be provided: • Annually to residents, representatives and staff • Upon request • Posted in a conspicuous location on the organization's website • Posted in a prominent and trafficked location in the building (no smaller than 20-point Sans Serif font) Sample non-discrimination notice (HHS)	

	beneficiaries, enrollees (including late and special enrollees), and applicants of its health program or activity; (ii) Upon request; (iii) At a conspicuous location on the covered entity's health program or activity website, if it has one; and (iv) In clear and prominent physical locations, in no smaller than 20-point sans serif font, where it is reasonable to expect individuals seeking service from the health program or activity to be able to read or hear the notice. (b) A covered entity may combine the content of the notice required by paragraph (a) of this section with the notices required by 45 CFR 80.6(d), 84.8, 86.9, and 91.32 if the combined notice clearly informs individuals of their civil rights under section 1557 and this part, so long as it includes each of the elements required by paragraph (a)(1) of this section.		
Subpart A **§ 92.11 Notice of availability of language assistance services and auxiliary aids and services**	(a) A covered entity must provide a notice of availability of language assistance services and auxiliary aids and services that, at minimum, states that the covered entity, in its health programs or activities, provides language assistance services and appropriate auxiliary aids and services free of charge, when necessary for compliance with section 1557 or this part, to participants, beneficiaries, enrollees, and applicants of its health program or activities, and members of the public. (b) The notice required under paragraph (a) of this section must be provided in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency of the relevant State or States in which a covered entity operates and must be provided in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication.	Providers must post the availability of language assistance services, auxiliary aids and services, free of charge, to residents and their representatives. This must be provided in English and the 15 languages most commonly spoken by individuals with limited English proficiency in the state (or states) in which the organization operates, as well as in alternate formats for individuals with disabilities who require auxiliary aids and services. • Top 15 non-English languages by state (CMS) • Translated Sample Notices (HHS) The notice must be provided: • Annually to residents, representatives and	Within one year of effective date. **July 5, 2025**

	(c) The notice required under paragraph (a) of this section must be provided in a covered entity's health program or activity, as follows: (1) On an annual basis to participants, beneficiaries, enrollees (including late and special enrollees), and applicants of its health program or activity; (2) Upon request; (3) At a conspicuous location on the covered entity's health program or activity website, if it has one; (4) In clear and prominent physical locations, in no smaller than 20-point sans serif font, where it is reasonable to expect individuals seeking service from the health program or activity to be able to read or hear the notice; and (5) In the following electronic and written communications when these forms are provided by a covered entity: (i) Notice of nondiscrimination required by § 92.10; (ii) Notice of privacy practices required by 45 CFR 164.520; (iii) Application and intake forms; (iv) Notices of denial or termination of eligibility, benefits or services, including Explanations of Benefits, and notices of appeal and grievance rights; (v) Communications related to an individual's rights, eligibility, benefits, or services that require or request a response from a participant, beneficiary, enrollee, or applicant; (vi) Communications related to a public health emergency; (vii) 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); (viii) Discharge papers; (ix) Communications related to the cost and payment of care with respect to an individual, including	staff • Upon request • Posted in a conspicuous location on the organization's website • Posted in a prominent and trafficked location in the building (no smaller than 20-point Sans Serif font) • In the following communications when provided by the covered entity: ○ Notice of nondiscrimination required by § 92.10 (see above); ○ Notice of privacy practices required by 45 CFR 164.520; ○ Application and intake forms ○ Notices of denial or termination of eligibility, benefits or services, including Explanations of Benefits, and notices of appeal and grievance rights ○ Communications related to an individual'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 ○ Discharge papers ○ Communications related to the cost and payment of care ○ Complaint forms ○ Patient and member handbooks Providers will be seen as compliant with this section if they: • Allow individuals to opt out of annual receipt	

	medical billing and collections materials, and good faith estimates required by section 2799B–6 of the Public Health Service Act; (x) Complaint forms; and (xi) Patient and member handbooks. (d) A covered entity shall be deemed in compliance with this section with respect to an individual if it exercises the option to: (1) On an annual basis, provide the individual with the option to opt out of receipt of the notice required by this section in their primary language and through any appropriate auxiliary aids and services, and: (i) Does not condition the receipt of any aid or benefit on the individual's decision to opt out; (ii) Informs the individual that they have a right to receive the notice upon request in their primary language and through the appropriate auxiliary aids and services; (iii) Informs the individual that opting out of receiving the notice is not a waiver of their right to receive language assistance services and any appropriate auxiliary aids and services as required by this part; (iv) Documents, on an annual basis, that the individual has opted out of receiving the notice required by this section for that year; and (v) Does not treat a non-response from an individual as a decision to opt out; or (2) Document the individual's primary language and any appropriate auxiliary aids and services and: (i) Provides all materials and communications in that individual's primary language and through any appropriate auxiliary aids and services; or (ii) Provides the notice required by paragraph (a) of this section in that individual's primary language and through any appropriate auxiliary aids and	of the notice (must be in individual's primary language or through appropriate auxiliary aids and services), under the following conditions: ○ Opting out is not a condition for receipt of services or seen as a waiver of rights ○ The individual has the right to receive the notice upon request ○ Selection of opting out is documented annually ○ A non-response is not treated as a decision to opt out • Document each resident's primary language and appropriate auxiliary aids and services and: ○ Provide materials and communications in the resident's primary language and/or through auxiliary aids or services ○ Provide the notice of language services in the resident's primary language and/or through auxiliary aids or services in all the communications listed above	

	services in all communications that are identified in paragraph (c)(5) of this section.		
Subpart C **§ 92.201 Meaningful access for individuals with limited English proficiency**	**(a) General requirement.** A covered entity must take reasonable steps to provide meaningful access to each individual with limited English proficiency (including companions with limited English proficiency) eligible to be served or likely to be directly affected by its health programs and activities. **(b) Language assistance services requirements**. Language assistance services required under paragraph (a) of this section must be provided free of charge, be accurate and timely, and protect the privacy and the independent decision-making ability of the individual with limited English proficiency. **(c) Specific requirements for interpreter and translation services.** (1) When interpretation services are required under this part, a covered entity must offer a qualified interpreter in its health programs and activities. (2) When translation services are required under this part, a covered entity must utilize the services of a qualified translator in its health programs and activities. (3) If a covered entity uses machine translation when the underlying text is critical to the rights, benefits, or meaningful access of an individual with limited English proficiency, when accuracy is essential, or when the source documents or materials contain complex, non-literal or technical language, the translation must be reviewed by a qualified human translator. **(d) Evaluation of compliance.** In evaluating whether a covered entity has met its obligation under paragraph (a) of this section, the Director shall: (1) Evaluate, and give substantial weight to, the nature and importance of the health program or activity and	Providers must identify residents with limited English proficiency and provide meaningful access to accurate and timely language services (including translation) free of charge. The provider cannot charge the resident for any of these services. When an interpreter or translation services are required for the residents identified above, providers must provide a qualified interpreter* or translator. When utilizing machine translation (e.g. Amazon or Google translation services) for something critical to the rights, benefits or meaningful access of the resident, the translation should be reviewed by a qualified human translator. Providers are expected to meet this requirement effectively for all residents identified above. Specifically, providers cannot rely on: • An adult not qualified as an interpreter, except as a temporary measure or at the request of the resident (however, this request must be made through a qualified interpreter) • A minor or a child, except in an emergency situation • Staff that are not qualified interpreters *The final rule defines a qualified interpreter as follows: *Qualified interpreter for an individual with limited English proficiency means an interpreter who via*	**July 5, 2024**

	the particular communication at issue, to the individual with limited English proficiency; and (2) Take into account other relevant factors, including the effectiveness of the covered entity's written language access procedures for its health programs and activities, that the covered entity has implemented pursuant to § 92.8(d). **(e) Restricted use of certain persons to interpret or facilitate communication.** A covered entity must not, in its health programs and activities: (1) Require an individual with limited English proficiency to provide their own interpreter, or to pay the cost of their own interpreter; (2) Rely on an adult, not qualified as an interpreter, to interpret or facilitate communication, except: (i) As a temporary measure, while finding a qualified interpreter in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available and the qualified interpreter that arrives confirms or supplements the initial communications with an initial adult interpreter; or (ii) Where the individual with limited English proficiency specifically requests, in private with a qualified interpreter present and without an accompanying adult present, that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, the request and agreement by the accompanying adult is documented, and reliance on that adult for such assistance is appropriate under the circumstances; (3) Rely on a minor child to interpret or facilitate communication, except as a temporary measure while	*a remote interpreting service or an on-site appearance:* *(1) Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language (qualified interpreters for relay interpretation must demonstrate proficiency in two non-English spoken languages);* *(2) Is able to interpret effectively, accurately, and impartially to and from such language(s) and English (or between two non-English languages for relay interpretation), using any necessary specialized vocabulary or terms without changes, omissions, or additions and while preserving the tone, sentiment, and emotional level of the original oral statement; and* *(3) Adheres to generally accepted interpreter ethics principles, including client confidentiality*. Providers can use video interpreting services as long as: • it is a high quality connection • allows for real time video and audio • the interpreters face can be seen clearly • there is adequate training provided to the users of the services. Providers can use audio interpreting services as long as: • it is a high quality connection • allows clear and audible transmission of voices • there is adequate training provided to the	

	finding a qualified interpreter in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available and the qualified interpreter that arrives confirms or supplements the initial communications with the minor child; or (4) Rely on staff other than qualified interpreters, qualified translators, or qualified bilingual/multilingual staff to communicate with individuals with limited English proficiency. **(f) Video remote interpreting services.** A covered entity that provides a qualified interpreter for an individual with limited English proficiency through video remote interpreting services in the covered entity's health programs and activities must ensure the modality allows for meaningful access and must provide: (1) Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; (2) A sharply delineated image that is large enough to display the interpreter's face and the participating person's face regardless of the person's body position; (3) A clear, audible transmission of voices; and (4) Adequate training for users of the technology and other involved persons so that they may quickly and efficiently set up and operate the video remote interpreting. **(g) Audio remote interpreting services**. A covered entity that provides a qualified interpreter for an individual with limited English proficiency through audio remote interpreting services in the covered entity's health programs and activities	users of the services.	

	must ensure the modality allows for meaningful access and must provide: (1) Real-time audio over a dedicated high-speed, wide-bandwidth connection or wireless connection that delivers high-quality audio without lags or irregular pauses in communication; (2) A clear, audible transmission of voices; and (3) Adequate training for users of the technology and other involved persons so that they may quickly and efficiently set up and operate the remote interpreting services. **(h) Acceptance of language assistance services is not required.** Nothing in this section shall be construed to require an individual with limited English proficiency to accept language assistance services		
Subpart C **§ 92.202 Effective communication for individuals with disabilities.**	(a) A covered entity must take appropriate steps to ensure that communications with individuals with disabilities (including companions with disabilities), are as effective as communications with nondisabled individuals in its health programs and activities, in accordance with the standards found at 28 CFR 35.130 and 35.160 through 35.164. Where the regulatory provisions referenced in this section use the term "public entity," the term "covered entity" shall apply in its place. (b) A covered entity must 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.	Providers are expected to ensure residents with disabilities have access to communications in the same way as individuals without disabilities. Auxiliary aids and services must be provided, free of charge, to residents with disabilities.	**July 5, 2024**
Subpart C **§ 92.203 Accessibility for**	(a) No qualified individual with a disability shall, because a covered entity's facilities are inaccessible to or unusable by individuals with disabilities, be denied the benefits of, be excluded from participation in, or otherwise be subjected to	Residents with disabilities cannot be denied benefits or excluded from participation due to inaccessible or unusable facilities.	**July 5, 2024**

buildings and facilities	discrimination under any health program or activity to which this part applies. (b) Each facility or part of a facility in which health programs or activities are conducted that is constructed or altered by or on behalf of, or for the use of, a recipient or State Exchange must comply with the 2010 Standards if the construction or alteration was commenced on or after July 18, 2016, except that if a facility or part of a facility in which health programs or activities are conducted that is constructed or altered by or on behalf of, or for the use of, a recipient or State Exchange, was not covered by the 2010 Standards prior to July 18, 2016, such facility or part of a facility must comply with the 2010 Standards if the construction or alteration was commenced after January 18, 2018. If construction or alteration was begun on or after July 18, 2016, and on or before January 18, 2018, in conformance with UFAS, and the facility or part of the facility was not covered by the 2010 Standards prior to July 18, 2016, then it shall be deemed to comply with the requirements of this section and with 45 CFR 84.23(a) and (b). Departures from particular technical and scoping requirements by the use of other methods are permitted where substantially equivalent or greater access to and usability of the facility is provided. All newly constructed or altered buildings or facilities subject to this section must comply with the requirements for a "public building or facility" as defined in section 106.5 of the 2010 Standards. (c) Each facility or part of a facility in which health programs or activities under this part are conducted that is constructed or altered by or on behalf of, or for the use of, a recipient or State Exchange in conformance with the 1991 Standards at appendix D to 28 CFR part 36 or the 2010 Standards shall be deemed to comply with the requirements of this section and with 45 CFR 84.23(a) and (b) with respect to those facilities, if the construction or alteration was commenced before July 18, 2016. Each facility or part of a facility in which health programs or activities are conducted that is constructed or	(The construction standards are not a new provision; they mirror the already existing standards under 92.103 (current Subpart B). So, providers should already be complying with this component of the rule.)	

	altered by or on behalf of, or for the use of, a recipient or State Exchange in conformance with UFAS shall be deemed to comply with the requirements of this section and with 45 CFR 84.23(a) and (b), if the construction or alteration was commenced before July 18, 2016, and such facility would not have been required to conform with a different accessibility standard under 28 CFR 35.151.		
Subpart C **§ 92.204 Accessibility of information and communication technology for individuals with disabilities.**	(a) A covered entity must ensure that its health programs and activities provided through information and communication technology are accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burdens or a fundamental alteration in the nature of the health programs or activities. If an action required to comply with this section would result in such an alteration or such burdens, a covered entity shall take any other action that would not result in such an alteration or such burdens but would nevertheless ensure that, to the maximum extent possible, individuals with disabilities receive the benefits or services of the health program or activity provided by the covered entity. (b) A recipient or State Exchange shall ensure that its health programs and activities provided through websites and mobile applications comply with the requirements of section 504 of the Rehabilitation Act, as interpreted consistent with title II of the ADA (42 U.S.C. 12131 through 12165).	Providers who offer Information and Communication Technology (ICT)* services, such as computer kiosks, must make sure they are accessible to individuals with disabilities, unless doing so would result in undue financial burden or changes to the program/activities. The same requirement applies to websites and mobile applications where health programs and activities are provided. *The final rule provides the following definition of Information and Communication Technology: *Information and communication technology (ICT) means information technology and other equipment, systems, technologies, or processes, for which the principal function is the creation, manipulation, storage, display, receipt, or transmission of electronic data and information, as well as any associated content. Examples of ICT include but are not limited to: computers and peripheral equipment; information kiosks and transaction machines; telecommunications equipment; telehealth interfaces or applications; customer premises equipment; multifunction office machines; software; mobile applications; websites; videos; and electronic documents.*	**July 5, 2024**

Subpart C **§ 92.205 Requirement to make reasonable modifications**	A covered entity must make reasonable modifications to policies, practices, or procedures in its health programs and activities when such modifications are necessary to avoid discrimination on the basis of disability, unless the covered entity can demonstrate that making the modifications would fundamentally alter the nature of the health program or activity. For the purposes of this section, the term "reasonable modifications" shall be interpreted in a manner consistent with the term as set forth in the ADA title II regulation at 28 CFR 35.130(b)(7).	Providers should review their policies and procedures to identify any modifications needed to avoid discriminating on the basis of disabilities.	**July 5, 2024**
Subpart C **§ 92.206 Equal program access on the basis of sex.**	(a) A covered entity must provide individuals equal access to its health programs and activities without discriminating on the basis of sex. (b) In providing access to health programs and activities, a covered entity must not: (1) Deny or limit health services, including those that have been typically or exclusively provided to, or associated with, individuals of one sex, to an individual based upon the individual's sex assigned at birth, gender identity, or gender otherwise recorded; (2) Deny or limit, on the basis of an individual's sex assigned at birth, gender identity, or gender otherwise recorded, a health care professional's ability to provide health services if such denial or limitation has the effect of excluding individuals from participation in, denying them the benefits of, or otherwise subjecting them to discrimination on the basis of sex under a covered health program or activity; (3) Adopt or apply any policy or practice of treating individuals differently or separating them on the basis of sex in a manner that subjects any individual to more than de minimis harm, including by adopting a policy or engaging in a practice that prevents an individual from participating in a health program or activity consistent with the individual's gender identity; or (4) Deny or limit health services sought for purpose of gender transition or other gender affirming care that	Providers cannot discriminate against residents on the basis of sex or identified gender. This includes: • Denying or limiting services • Adopting a policy that treats individuals differently or separately that may cause harm	**July 5, 2024**

	the covered entity would provide to an individual for other purposes if the denial or limitation is based on an individual's sex assigned at birth, gender identity, or gender otherwise recorded. (c) Nothing in this section requires the provision of any health service where the covered entity has a legitimate, nondiscriminatory reason for denying or limiting that service, including where the covered entity typically declines to provide the health service to any individual or where the covered entity reasonably determines that such health service is not clinically appropriate for a particular individual. A covered entity's determination must not be based on unlawful animus or bias or constitute a pretext for discrimination. Nothing in this section is intended to preclude a covered entity from availing itself of protections described in §§ 92.3 and 92.302. (d) The enumeration of specific forms of discrimination in paragraph (b) of this section does not limit the general applicability of the prohibition in paragraph (a) of this section		
Subpart C **§ 92.208 Prohibition on sex discrimination related to marital, parental, or family status**	In determining whether an individual satisfies any policy or criterion regarding access to its health programs or activities, a covered entity must not take an individual's sex, as defined in § 92.101(a)(2), into account in applying any rule concerning an individual's current, perceived, potential, or past marital, parental, or family status.	Providers cannot discriminate against individuals on the basis of their sex when applying an eligibility rule that applies to marital, parental or family status. For example, protecting marital rights for a same-sex married couple.	**July 5, 2024**
Subpart C **§ 92.209 Nondiscrimination on the basis of association**	A covered entity must not exclude from participation in, deny the benefits of, or otherwise discriminate against an individual or entity in its health programs and activities on the basis of the respective race, color, national origin, sex, age, or disability of the individual and another person with whom the individual or entity has a relationship or association	This requirement indicates that a resident cannot be discriminated against on the basis of their association or relationship with another individual.	**July 5, 2024**
Subpart C	**(a) General prohibition.** A covered entity must not discriminate on the basis of race, color, national origin, sex,	If the provider uses any patient support tools, they should evaluate whether there is any risk of	92.210(a) General prohibition

§ 92.210 Nondiscrimination in the use of patient care decision support tools.	age, or disability in its health programs or activities through the use of patient care decision support tools. **(b) Identification of risk.** A covered entity has an ongoing duty to make reasonable efforts to identify uses of patient care decision support tools in its health programs or activities that employ input variables or factors that measure race, color, national origin, sex, age, or disability. **(c) Mitigation of risk.** For each patient care decision support tool identified in paragraph (b) of this section, a covered entity must make reasonable efforts to mitigate the risk of discrimination resulting from the tool's use in its health programs or activities.	discrimination through the use of those tools and take steps to mitigate that risk.	**July 5, 2024** § 92.210(b), (c) Identification and Mitigation of risk - Within 300 days of effective date. **May 1, 2025**
Subpart C **§ 92.211 Nondiscrimination in the delivery of health programs and activities through telehealth services.**	A covered entity must not, in delivery of its health programs and activities through telehealth services, discriminate on the basis of race, color, national origin, sex, age, or disability.	This requirement reiterates that the provider cannot discriminate through telehealth services.	**July 5, 2024**