SPECIAL REPORT

HHS PROPOSES TO UPDATE DISABILITY NONDISCRIMINATION REGULATIONS FOR FIRST TIME IN NEARLY 50 YEARS

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McDermott Will & Emery

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OVERVIEW

Discrimination on the basis of disability has contributed to significant disparities in healthcare and child welfare. To address these disparities, the US Department of Health and Human Services (HHS) has proposed updated regulations implementing Section 504 of the Rehabilitation Act of 1973 to prohibit discrimination on the basis of disability in programs or activities that receive HHS funds. Although most of the revisions align with expectations imposed on stakeholders through other federal laws, some proposed changes are unique to HHS programs, including regulations impacting medical treatment, value assessments, medical diagnostic equipment, digital media and child welfare programs.

INTRODUCTION

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the basis of disability in programs or activities that receive federal financial assistance from any federal department or agency, including the US Department of Health and Human Services. HHS implemented Section 504 into rules applicable to hospitals, nursing homes, mental-health centers and other human-service programs in 1977. Those rules remained unchanged over the decades, leading to some inconsistencies with other federal civil rights laws. Recognizing the impact that discrimination has played in denying individuals with a disability an equal opportunity to participate in healthcare programs and benefit from quality healthcare, HHS has proposed a sweeping set of rules in a Notice of Proposed Rulemaking (NPRM), published on September 14, 2013. Per HHS, the NPRM strives to ensure that "people with disabilities . . . are not excluded from or discriminated against in health care and social services . . . from denial of medical treatment due to ableism, to inaccessible medical equipment and websites, to having no choice but to receive services in institutional settings." In doing so, the NPRM also removes outdated terminology and regulatory provisions in efforts to align Section 504 with other laws, regulations, Supreme Court cases, executive orders and disability-rights advocacy efforts.

Although HHS is requesting comment on several components of the NPRM, we anticipate that most of the provisions will be promulgated in largely the same form as proposed, given the significant overlap of Section 504 with the Americans with Disabilities Act of 1990 (ADA), the Americans with Disabilities Act Amendments Act of 2008 (ADAAA) and Section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

We hope this summary of the NPRM provides a useful primer.

WHAT IS SECTION 504?

Section 504 of the Rehabilitation Act states that no otherwise qualified individual with a disability shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance, or conducted by an executive agency or the US Postal Service, solely by reason of such disability.

WHAT PROGRAMS OR ACTIVITIES RECEIVING FEDERAL FINANCIAL ASSISTANCE ARE AFFECTED BY THE NPRM?

The NPRM is advanced by HHS. Accordingly, any entity that receives any money from HHS (a "recipient"), including credits, subsidies or contracts of insurance, is implicated in the NPRM. Currently, this means that entities participating in more than 100 programs—including Medicare Part A, Medicare Part C and Medicare Part D; Medicaid; the Children's Health Insurance Program; Temporary Assistance for Needy Families; Head Start; the Supplemental Nutrition Assistance Program; child care, foster care and adoption programs; human subjects research protection; and many others—would be a recipient under the NPRM. Medicare Part B's qualification as federal financial assistance is currently under consideration through separate proposed rulemaking amending Section 1557 regulations.

WHO IS A QUALIFIED INDIVIDUAL WITH A DISABILITY?

Under the ADA, a "disability" means a physical or mental impairment that substantially limits one or more major life activities, including but not limited to caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working.

The NPRM proposes to adopt this definition and further emphasizes an intentionally broad application of its nondiscrimination provisions to any "individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a recipient."

WHAT NEW NONDISCRIMINATION REQUIREMENTS ARE PROPOSED IN THE NPRM?

Five material revisions are proposed for appending into existing Section 504 regulations. These revisions further clarify and specify expectations for recipients and help individuals with a disability to better understand their rights to participate in HHS programs and activities without fear of discrimination on the basis of disability.

1. Medical treatment

Broadly speaking, Section 504 prohibits discrimination in medical treatment on the basis of disability. "Medical treatment" is intended to apply broadly to any management or care of a patient to identify, address, treat or ameliorate a physical or mental health condition, injury, disorder or symptom, irrespective of whether the medical treatment is related to the individual's disability.

HHS observed that physicians have historically held certain opinions regarding individuals with a disability, including citing a study finding that 82% of doctors felt that individuals with a disability had a worse quality of life than people without disabilities. This opinion is contrary to self-reported levels of happiness experienced by many people with disabilities—particularly when they can access healthcare services and the supports necessary to participate in their communities.

To address this disconnect, throughout the 121-page NPRM, HHS emphasizes that biased and stigmatized perceptions about the quality of life experienced by individuals with disabilities is discriminatory and unacceptable. Disparate treatment, such as demotion on organ transplant lists, denial of life-sustaining treatment, facing unequal treatment under crisis standard of care protocols, and exclusion from clinical research despite otherwise meeting qualification criteria, is a common experience when individuals with disabilities seek medical care to which they are entitled. Under the proposed rules, HHS makes it clear that, in medical treatment, recipients may not categorically exclude or discriminate against individuals with a disability solely based on that individual's disability. Medical decisions instead must be made using nondiscriminatory criteria for administering treatment or allocating resources.

For example, if crisis standards of care included protocols to deprioritize care for patients with a more severe Glasgow Coma Scale score as a proxy for assessing short-term likelihood of mortality, applying that score to individuals with speech or mobility issues

due to acute brain injuries may be appropriate; however, using the same scoring system to individuals with autism or cerebral palsy would be discriminatory, as those individuals' speech and mobility challenges have no relation to short-term survival. Similarly, it would be discriminatory to deny a ventilator to a patient with COVID-19 solely because that patient has spinal muscular atrophy if a ventilator would be offered to a similarly situated individual without that condition. It would also be discriminatory to deny providing naloxone to a person with substance-use disorder based on a belief that this individual is likely to relapse or unlikely to adhere to treatment protocols.

If an individual qualifies to receive medical treatment and consents to such treatment, the NPRM makes clear that making medical decisions based on a perception of the patient's disability rather than by consideration of the effectiveness of treatment or other legitimate reason, such action would be considered discriminatory under Section 504. Providers are not obligated to deliver services outside of their scope of practice, and the NPRM is not proposing to usurp professional judgment in medical treatment decisions, but all such decisions should be made based on individualized, fact-specific inquiries and legitimate nondiscriminatory reasons to deny or limit treatment or to recommend an alternative course of action.

2. Using value assessments

As previously stated, the NPRM commands recipients to avoid discounting the value of an individual's life on the basis of disability. To further that instruction, HHS proposes to consider it a violation of Section 504 to use value assessments that place a lower value on life extension for a group of individuals based on disability if such methods are then used to deny or afford an unequal opportunity to receive an aid, benefit or service.

An example of a discriminatory value assessment would include evaluating a drug's effectiveness in extending the lives of individuals without a disability compared to those with a disability and using that data to establish utilization management controls or to make drug formulary tiering decisions. That said, value assessments are not necessarily prohibited automatically. Recipients may continue to use value assessments in academic research or other circumstances where the measure is not used to deny or create an unequal opportunity to access entitled services. Rather, HHS observed that recipients often use value assessments when making decisions regarding coverage, cost, eligibility or referrals, or when providing or withdrawing care, all of which can have serious implications on the well-being of individuals with disabilities and their ability to access necessary care and services.

3. Accessible medical equipment

A lack of accessible medical diagnostic equipment (MDE) has been an acute source of harm faced by people with disabilities, resulting in injuries to patients, caregivers and medical staff, missed appointments for routine or preventative services, or below-standard care provided to individuals with disabilities. Adjustable-height examination tables and chairs, examination tables with side rails, wheelchair-accessible scales, accessible radiologic equipment, portable floor and overhead track lifts, gurneys and stretchers are all examples of accessible medical equipment.

In 2017, the US Architectural and Transportation Barriers Compliance Board (Access Board) published Standards for Accessible Medical Diagnostic Equipment (MDE Standards), which were finalized as part of Section 510 of the Rehabilitation Act in 2017 and reissued in 2022. As the 2017 MDE Standard rule observed, the Access Board was empowered to establish the MDE Standards but had no authority to

enforce compliance. Therefore, the NPRM proposes to adopt the MDE Standards as the technical requirements necessary to ensure that accessible medical diagnostic equipment is available to individuals with disabilities and to give the HHS Office of Civil Rights authority to enforce recipient compliance with such standards. Some highlights of the MDE Standards as proposed in the NPRM include the following:

- All MDE that a recipient acquires after the effective date must be accessible until the recipient meets certain adequacy criteria:
  - » For general-purpose providers, this includes ensuring that at least 10% but no fewer than one unit of each type of equipment complies with MDE Standards.
  - » For providers specializing in treating conditions that affect mobility, at least 20% but no fewer than one unit of each type of equipment must comply with MDE Standards.
- Recipients with multiple departments, clinics or specialties that utilize MDE must ensure accessible equipment is proportionately dispersed to provide individuals with a disability an equal opportunity to benefit from each type of medical care provided by the recipient. This does not obligate the recipient to acquire more equipment than the aforementioned adequacy standards; rather, it requires that accessible equipment be available for those who would benefit from it.
- Recipients that use exam tables and scales must acquire at least one accessible exam table and at least one accessible scale within two years of the NPRM's finalization, unless such accessible equipment is already in place.
- Recipients may use alternative, equivalent designs but only to the extent such equivalency exceeds the MDE Standards. Recipients also are not required to alter sophisticated medical equipment such that it fundamentally affects the integrity of the equipment. However, if such a circumstance occurs, recipients must develop workarounds to ensure that individuals with disabilities can access the equipment. For example, a recipient would not be required to alter the configuration of a positron emission tomography (PET) machine, but they may need to establish protocols for transferring patients from a wheelchair to the PET machine table.
- HHS is considering applying the MDE Standards to non-diagnostic equipment such as infusion chairs used to dispense chemotherapy drugs, dialyzers, infusion pumps, exercise and rehabilitation equipment, and other specialized equipment.
- Recipients' staff must be trained to successfully operate accessible MDE, assist with transferring and positioning individuals with disabilities, and generally carry out the obligations to ensure individuals with disabilities can benefit from accessing MDE.

4. Accessibility in websites, mobile applications and kiosks

Many civil rights statutes, including the 2022 proposed rules implementing Section 1557 of the Affordable Care Act, require covered entities to ensure that health programs or activities provided through digital technology are accessible to individuals with a disability, unless doing so would fundamentally alter the program or activity or pose an undue financial or administrative burden. The NPRM uses this language, and guidance from the US Department of Justice on website accessibility, to require recipients to make mobile applications, websites and kiosks accessible to individuals with a disability. For the sake of the NPRM, a "kiosk" is defined as a self-service transaction

machine made available for the independent use of patients or program participants in health and service programs or activities, often consisting of a screen and input device such as a keyboard, touch screen or similar device, onto which the program participant independently enters information.

To be considered accessible, web content, mobile applications and kiosks must meet the technical standards set forth in the Web Content Accessibility Guidelines (WCAG) 2.1. HHS felt that web developers and professionals who work with entities subject to Section 504 are likely familiar with WCAG 2.1 standards and therefore compliance will not be overly burdensome. HHS further proposes that a recipient's webpage or mobile application must meet Level AA accessibility standards, which ensures accessibility for individuals with visual, auditory, physical, speech, cognitive and neurological disabilities at a level that is feasible for most web developers to implement. The standard is proposed to be the same for all recipients regardless of the size of the organization, but the NPRM also proposes a delayed implementation date for smaller entities.

Recognizing that websites often link to external sources or may have user-generated information, the NPRM proposes that the WCAG 2.1 Level AA standard will generally apply only to web content that the recipient itself makes available to members of the public. For example, if a recipient posts onto a third-party social media platform, the recipient is not obligated to ensure the platform is accessible at a WCAG 2.1 Level AA standard, but any web content that the recipient itself provides on that platform should meet prescribed accessibility standards.

Recipients would be authorized to create conforming, alternate versions of a website as long as the alternate version is accessible, up to date, contains the same information and functionality as an inaccessible webpage, and can be reached via a conforming page or an accessibility-supported mechanism. However, this allowance should be exercised only when it is not possible to make a website and web content directly accessible due to technical limitations or legal limitations, or if full compliance would result in a fundamental alteration in the nature of a program or activity or present undue financial or administrative burden. HHS emphasizes that the burden of demonstrating the need for an alternate version is a heavy one, and recipients should take concerted efforts to avoid inconsistency with Section 504's core principles of inclusion and integration.

Notably, although the NPRM proposes WCAG 2.1 Level AA as the standard for accessibility, it is not the ceiling. If an individual with a disability cannot access or lacks equal access to web content or a mobile application on the basis of that disability, the individual with a disability must be provided with an alternative method of access to that program or activity. This proposal is consistent with obligations, under other civil rights statutes, to provide individuals with disabilities with auxiliary aids and services that will allow them to fully realize the benefits to which they are entitled.

Although HHS anticipates that most recipients are nearly (if not fully) compliant, recipients with more than 15 employees will have two years and recipients with fewer than 15 employees will have three years to meet WCAG 2.1 Level AA standards. The NPRM requested comments on whether this delay is necessary, how to measure compliance and what level of noncompliance might be considered acceptable.

Recognizing that not all web content is created the same, HHS proposes certain exceptions to the aforementioned accessibility standards:

- *Archived web content*

  Content that is maintained exclusively for reference, research or recordkeeping, is not altered or updated after the date of archiving, and is organized and stored in a dedicated area clearly identified as being archived, does not need to be converted to an accessible standard. However, if an individual with a disability requests access to accessible archived material, such a request should be accommodated. Further, it would not be acceptable for a recipient to convert all material to "archived" to avoid compliance obligations.

- *Preexisting conventional electronic documents*

  Web content and mobile app data that are stored as .pdf, word processing document, presentation file, spreadsheet or database formats before the effective date of the proposed regulations do not need to be converted to an accessible format, unless the materials are currently used by members of the public to apply for, gain access to, or participate in a recipient's programs or activities. Here, too, recipients are discouraged from converting all content to these exempt formats prior to the effective date, in order to avoid compliance obligations.

- *Web content posted by third parties on a recipient's website*

  The proposed WCAG 2.1 Level AA standard will apply to a message board or other interactive tool that a recipient provides to the public; however, HHS proposes to exempt content that a third-party posts on a recipient's interactive website. The exemption would not apply to third-party content such as calendars, scheduling tools, maps, payment systems and other third-party tools that the recipient provides to the public for purposes of accessing programs and services.

- *Third-party web content linked from a recipient's website*

  The NPRM also recognizes that websites often link to third-party web content and exempts such content from the proposed accessibility standard unless the purpose of the link is to allow members of the public to participate or benefit from covered programs or activities. For example, if a website links to nearby hotels and restaurants, there is not an obligation on the recipient to ensure that the restaurant's website is compliant. However, if the link goes to a website that allows a user to pay fees to enroll in a program or activity, then the linked website must be accessible or it could be said that individuals with a disability do not have equal opportunity to participate in the applicable program—even if the individual with disability can make a payment through another means such as via 24-hour monitored telephone service.

- *Password-protected course content for students enrolled in a specific course*

  Educational institutions that provide HHS-funded programs and activities to individuals with disabilities must comply with Section 504. However, not all classes are going to include an individual with a disability. The NPRM exempts course-specific, password-protected materials from the proposed accessibility standard when there is no student with a disability (or parent with a disability, in the case of elementary and secondary institutions) enrolled in that course. This exemption does not apply to content for classes or courses that are made available to the general public without enrolling at a particular institution, or to non-course content that is generally available to all students enrolled at an institution, such as class registration forms, meal plan applications, academic calendars or announcements. This standard is generally the

same as many other disability protections applicable to the school setting.

- *Conventional electronic documents that are about a specific individual, their property or their account and that are password protected*

  Digital versions of individualized documents made available to customers, constituents and other members of the public are exempt from the WCAG 2.1 Level AA standard when housed in a password-protected account. For example, a hospital may upload a .pdf of test results to a patient's portal without converting that .pdf to an accessible standard. However, if the patient is an individual with a disability, then the exemption no longer applies, and the content must be accessible for that particular patient. Content that is broadly applicable to all patients, such as an announcement regarding an upcoming rate change, would not meet this exemption, because it is not individualized for a specific person or their property or account.

5. Child welfare services

Section 504 considers federally funded child welfare programs and activities to be covered services, and therefore children with disabilities as well as parents, foster parents, prospective parents and other caregivers with disabilities are entitled to access to such services without being discriminated against because of their disability. The NPRM proposes to add a section clarifying that nondiscrimination provisions apply to child welfare programs and activities.

As to children with disabilities, the NPRM clarifies that child welfare agencies must place qualified individuals with disabilities in the most integrated setting appropriate to the needs of the child rather than unjustly segregating children with disabilities in institutional or other congregate-care facilities. This addition is consistent with regulations implementing the ADA.

When addressing caregivers with disabilities, HHS observes that individuals with disabilities should be provided with the same support services offered to other parents, adoptive parents, foster parents and caregivers. The NPRM references blind parents unjustly having children removed from their custody due to a lack of specialized parenting training, or intellectually disabled individuals being viewed as less capable to care for a child due to a lower IQ, or individuals with substance-use disorders being denied emergency custody placements—in each case, discrimination on the basis of disability when the disability was the sole reason for the decision.

Discrimination in child welfare services can take the form of decisions based on speculation, stereotypes or generalizations about a parent, caregiver, foster parent or prospective parent, or coercing or pressuring the decision-making efforts of an individual with a disability. As with other guidelines set forth in the NPRM, HHS emphasizes the importance of making determinations based on criteria that are agnostic to the individual's disability and ensuring that child welfare programs provide equal opportunities for caregivers, foster parents, companions or prospective parents with disabilities to benefit from such programs. HHS instructs recipients to provide individuals with disabilities with auxiliary aids and services and reasonable modifications, including such things as individualized parenting training, tests and assessments that are adapted to account for the parent's disability. Ultimately, child welfare decisions should be based on reasonable judgment derived from current medical knowledge and objective evidence.

WHAT IS THE ANTICIPATED BURDEN OF THE NEW RULES?

HHS estimates that the economic implications of the proposed rule will be modest, and the smallest groups of implicated recipients will experience less than a 3% reduction in revenue. Acquiring new MDE and training staff in its use may be the largest expense, but many recipients do not provide services that necessitate MDE. Similarly, updating websites to be accessible is an expense that many already incur through employment of web development staff. Further, many of the proposed changes are already familiar to recipients through compliance with ADA, ADAAA, Section 1557 and other civil rights laws.

WHEN WILL THE NEW RULES BECOME EFFECTIVE?

After HHS reviews and addresses comments and publishes a Final Rule, it will be effective 30 days after publication, with a few exceptions.

WHEN ARE COMMENTS ON THE NPRM DUE?

HHS has already shared, on its OCR Civil Rights ListServ, overwhelming support from disability rights advocates and other stakeholders. Nevertheless, recipients may find some components of the NPRM to be overly burdensome or insufficient to ensure meaningful access to HHS programs and activities for individuals with disabilities. Interested parties are encouraged to submit comments on or before November 7, 2023.

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