DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Director

Office for Civil Rights

Washington, D.C. 20201

January 7, 2025

Re: Nondiscrimination on the Basis of Disability: Section 504 of the Rehabilitation Act and Section 1557 of the Affordable Care Act

Dear Colleagues:

On May 9, 2024, the U.S. Department of Health and Human Services' (Department) Office for Civil Rights (OCR) published a final rule updating regulations implementing Section 504 of the Rehabilitation Act of 1973 (Section 504),[1] which prohibits discrimination on the basis of disability in any program or activity receiving Federal financial assistance. The rule went into effect on July 8, 2024. This rule clarifies and strengthens civil rights protections for people with disabilities in health and human service programs funded by the Department. In addition, on April 26, 2024, the Department issued a final rule updating regulations implementing Section 1557 of the Affordable Care Act (Section 1557),[2] which prohibits discrimination based on race, color, national origin, sex, age, or disability in covered health programs and activities.

To help recipients of Department financial assistance better understand their obligations under these rules, this letter highlights some of the key disability nondiscrimination requirements, including new obligations that require specific actions.

Overview of Disability Sections in Section 504 and Section 1557

Section 504 prohibits discrimination against qualified individuals with disabilities in health and human services programs and activities that receive Federal financial assistance. HHS has updated its Section 504 regulations to address nondiscrimination in modern health care systems and to clarify how Section 504 applies to key areas including medical treatment, value assessment methods, kiosks, web content and mobile apps, medical diagnostic equipment (MDE), effective communication, and integration.

Section 1557 also contains numerous protections for qualified individuals with disabilities that supplement the protections in Section 504. For instance, Section 1557 includes sections on disability protections related to effective communication, building accessibility, information and communication technology (ICT) accessibility, reasonable modifications, patient care decision support tools, and telehealth.

New Obligations Under Section 504

Medical Treatment, § 84.56

[1] 29 U.S.C. 794. The regulations are contained at 45 CFR part 84.
[2] 42 U.S.C. 18116. The regulations are contained at 45 CFR part 92.

While Section 504 has prohibited discrimination in any program or activity receiving Federal financial assistance since it was enacted in 1973, people with disabilities still face inequities in the medical treatment options that providers offer to them. Discrimination on the basis of disability in accessing medical care leads to significant health disparities and poorer health outcomes for people with disabilities. Stereotypes and bias too often play fundamental roles in denying people with disabilities access to health care. Research, including reports by the National Council on Disability, states that large proportions of practicing physicians hold biased or stigmatized perceptions of people with disabilities, perceiving them to have a lower quality of life because of their disabilities.[3]

Under the updated rule, health care providers must not deny or limit medical treatment to qualified individuals with disabilities based on biases or stereotypes about the patient's disability, judgments that the qualified individual will be a burden on others due to their disability, or on the belief that the life of a person with a disability has lesser value than the life of a person without a disability. Treatment also cannot be denied if it would be offered to a similarly situated individual without a disability. In addition, a recipient cannot offer treatment that would not be offered to a similarly situated person without a disability unless the disability impacts the effectiveness or ease of administration of the treatment itself, or has a medical effect on the condition to which the treatment is directed.

Section 504 contains genuine nondiscriminatory exceptions to its medical treatment decision obligations. The provision of medical treatment is not required where the recipient has a legitimate, nondiscriminatory reason for denying or limiting that service or where the disability renders the individual not qualified for the treatment. For example, where a patient's prognosis affects whether treatment is likely to be effective, it may be permissible to consider prognosis in determining whether a treatment should be provided. Similarly, where a treatment is likely to have substantial side effects that may outweigh the likely benefits to the patient, it may be permissible to take these into account in determining whether a treatment should be provided. However, consideration of a patient's prognosis may not include bias or stereotypes about a patient's disability or a judgment that the life of a person with a disability is not worth living or will be a burden on others due to their disability.

In addition, a recipient is not required to provide medical treatment when the treatment is outside their scope of practice (e.g., an orthopedic surgeon may decline to provide treatment to children with disabilities because pediatric surgery is not within her scope of service). Nor are recipients required to provide medical treatment if they have not obtained consent from an individual with a disability or their authorized representative, but recipients may not unduly pressure individuals with disabilities to consent to provide, withhold, or withdraw treatment. A recipient may provide information on the implications of different courses of treatment based on current medical knowledge or the best available objective evidence.

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[3] *See, e.g.,* Nat'l Council on Disability, Bioethics and Disability Report Series (2019), *https://ncd.gov/ publications/ 2019/ bioethics-report-series;* Tara Lagu et al., *The Axes of Access—Improving Care Quality for Patients with Disabilities,* 370 N. Engl. J. Med. 1847 (May 2014); Tara Lagu et al., *Ensuring Access to Health Care for Patients with Disabilities,* 175 JAMA Internal Med. 157 (Feb. 2015); Tim Gilmer, *Equal Health Care: If Not Now, When?,* New Mobility (July 1, 2013), *http://www.newmobility.com/ equal-health-care-if-not-now-when;* Gloria L. Krahn et al., *Persons with Disabilities as an Unrecognized Health Disparity Population,* 105 Am. J. of Public Health S198 (2015); Kristi L. Kirschner et al., *Structural Impairments that Limit Access to Health Care for Patients with Disabilities,* 297 JAMA 1121 (Mar. 2007).

OCR recommends that health care providers examine their policies and procedures and, where necessary, work with their staff to ensure that stereotypes and biases do not play a role in the provision of health care in their programs and activities.

Value Assessment Methods, § 84.57

Section 84.57 prohibits recipients from using any value measure, assessment, or tool that discounts the value of life extension on the basis of disability to deny or afford an unequal opportunity to qualified individuals with disabilities with respect to any eligibility determination or referral for, or provision or withdrawal of aid, benefit, or service. Value measures, assessments, or tools inform decisions for cost containment and quality improvement efforts in healthcare and help determine whether a particular intervention, such as medicine or treatment, will be provided and under what terms.

The rule does not prohibit the use of any specific method of value assessment because the determination that a value assessment method will be prohibited depends on the specific context and purpose for which that method is used. For example, some methods that are impermissible for purposes of reimbursement or utilization management decisions may be permitted for academic research.

Section 1557 contains similar nondiscrimination requirements for covered entities. Under § 92.210(a) of the Section 1557 regulations, covered entities may not discriminate on the basis of disability in their health programs or activities through the use of patient care decision support tools. In addition, § 92.210(b)-(c) places an ongoing duty on covered entities to make reasonable efforts to identify uses of patient care decision support tools that employ input variables or factors that measure disability and, for each patient care decision support tool identified as employing variables or factors that measure disability, each covered entity must make reasonable efforts to mitigate the risk of discrimination resulting from the tool's use, which go into effect on May 1, 2025.

Accessibility of Kiosks, § 84.83

The expanded use of self-service kiosks in medical settings has allowed recipients to automate portions of their programs and activities, but potentially limits accessibility for people with disabilities. The rule includes a general statement of nondiscrimination requiring accessible programs and activities when kiosks are used but it does not require compliance with any specific standard. To make their programs accessible, recipients may need to modify their policies, practices, and procedures to allow people with disabilities who cannot use kiosks because of their inaccessible features to access the program without using kiosks. Such alternate procedures must afford persons with disabilities the same access, the same convenience, and the same confidentiality that the kiosk system provides.

Web Content and Mobile App Accessibility, §§ 84.82 - 84.89

Health care programs increasingly rely on websites and mobile apps to convey information, schedule appointments, and even provide health services via telehealth. Unfortunately, some of this information provided via web content and apps remains inaccessible to people with certain disabilities.

The Section 504 rule requires that recipients ensure their web content and mobile applications are accessible to people with disabilities by complying with the success criteria of the Web Content and Accessibility Guidelines (WCAG) 2.1 AA. WCAG 2.1 AA, an internationally recognized private standard that the rule adopts, focuses on ensuring that web content and mobile apps are perceivable, operable, understandable, and robust for individuals with disabilities.

Recipients with fifteen or more employees must ensure that their web content and mobile apps conform with WCAG 2.1 AA by May 11, 2026, while recipients with fewer than fifteen employees must ensure conformance by May 10, 2027. Although there are exceptions for specific types of web content and mobile apps, including exceptions for archived web content, certain pre-existing conventional electronic documents, certain content posted by a third party, individualized, password-protected documents or otherwise secured conventional electronic documents, and preexisting social media posts, these exceptions do not supersede other requirements of the rule, such as the effective communication[4] and reasonable modification[5] requirements which took effect on July 8, 2024. There are limited exceptions for actions that would result in a fundamental alteration or undue financial and administrative burdens.

Similarly, **§** 92.204 of the Section 1557 regulations requires covered entities to ensure that health programs and activities provided through information and communication technology are accessible to individuals with disabilities, subject to the same limitation regarding actions that would result in a fundamental alteration or undue financial and administrative burdens. The section also requires recipients and State Exchanges to ensure that health programs and activities provided through websites and mobile applications comply with the requirements of Section 504. In addition, § 92.211 of the Section 1557 regulations prohibits discrimination in the delivery of telehealth services.

Medical Diagnostic Equipment (MDE), § § 84.90 - 84.94

Accessible MDE, including MDE that patients lie on, sit on, transfer to, use while seated in a wheelchair, or stand to use, is vital for health equity, person-centered care, and access to care for patients with disabilities. Researchers have demonstrated and documented that the scarcity of accessible MDE constitutes a significant barrier to access to care for patients with disabilities, resulting in a lack of preventative care and diagnostic exams and contributing to poorer health outcomes and lower life expectancies.[6] Patients with disabilities have told HHS that they have been unable to receive proper medication dosages because their doctors do not have wheelchair-

[4] 45 CFR §§ 84.77-81.
[5] 45 CFR § 84.68(b)(7).
[6] *See, e.g.*, Nat'l Council on Disability, Enforceable Accessible Medical Equipment Standards: A Necessary Means to Address the Health Care Needs of People with Mobility Disabilities (2021), https://www.ncd.gov/assets/uploads/reports/ncd_medical_equipment_report_508.pdf; Nat'l Council on Disability, 2021 Progress Report: The Impact of Covid on People with Disabilities (2021), https://www.ncd.gov/assets/uploads/reports/2021/ncd-2021-progress-report-covid-19.pdf (''the lack of accessible examination and medical equipment in medical care means that people with disabilities, specifically people with mobility disabilities, receive substandard primary care compared to people without disabilities.''); Anna Marrocco and Helene J Krouse, *Obstacles to preventive care for individuals with disability: Implications for nurse practitioners*, J. Am. Ass'n of Nurse Pract. 2017 May; 29(5):282–293 (2017) at 289; U.S. Dep't of Health & Human Servs., Off. of the Surgeon Gen., The Surgeon General's Call To Action To Improve the Health and Wellness of Persons with Disabilities, (2005), *available at* https://www.ncbi.nlm.nih.gov/books/NBK44667/ (last visited Dec. 2, 2021).

accessible scales or they have not been able to receive a proper physical exam because existing exam tables do not lower (or do not lower sufficiently) for them to transfer onto.[7] .

Beginning July 8, 2024, the rule requires that when recipients purchase, lease, or otherwise acquire MDE, they acquire accessible MDE until they meet scoping thresholds required by the final rule. These thresholds are 20% of diagnostic equipment for programs and activities that specialize in treating conditions related to mobility and 10% for all other programs and activities.[8] This newly acquired accessible MDE must meet the Standards for Accessible MDE issued by the U.S. Access Board.[9]

The rule also requires that, if recipients use exam tables or weight scales, they must have in place one accessible type of this equipment by July 8, 2026, if the recipient has fifteen or more employees and by July 8, 2027, if the recipient has fewer than fifteen employees.

Recipients must ensure their staff are qualified to successfully operate accessible MDE, assist with transfers, and ensure program accessibility of MDE.

Regarding existing MDE, the rule requires that recipients operate their programs and activities offered through or with the use of MDE so that, when viewed in their entirety, they are readily accessible to and usable by individuals with disabilities. Recipients are not necessarily required to make each piece of MDE they use accessible.

Like other sections of the rule, there are limited exceptions for actions that would result in a fundamental alteration of the program or activity or undue financial and administrative burdens.

Other Key Provisions

Effective Communications, §§ 84.77 - 84.81

Communication failures in health services can be life-altering or even fatal. Ensuring that communications with individuals with disabilities are as effective as communications with others helps to avoid such failures and helps protect the health of people with disabilities. Over the years, OCR has received numerous complaints alleging that recipients denied people with disabilities effective communication or failed to provide appropriate auxiliary aids and services like sign language interpreters, assisted listening devices, or documents in Braille. To address this persistent manifestation of discrimination against individuals with disabilities, the rule requires recipients to take appropriate steps to ensure that communications with applicants, participants, members of the public, and companions with disabilities are as effective as communications with others.

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[7] *See* DeSouza, *Analysis of Low Wheelchair Seat Heights and Transfer Surfaces for Medical Diagnostic Equipment*, https://www.access-board.gov/research/human/wheelchair-seat-height/ (providing research on wheelchair seat heights and percentages of wheelchair users that can transfer to 17, 18, and 19 inch surfaces). *See also*, U.S. Access Board, *Access Board Review of MDE Low Height and MSRP* (Dec. 5, 2022), https://www.regulations.gov/docket/ATBCB-2023-0001 (providing more details on accessible exam table heights and prices).

[8] *See* 45 CFR 84.92(b)(1) and (2).

[9] Section 504 and the Standards for Accessible MDE contain one key difference. Section 504 requires a low transfer height for exam tables and chairs of 17-19 inches, while the Access Board recently published a final rule updating the Standards for Accessible MDE to require a low transfer height of 17 inches (89 FR 60307 (July 25, 2024).

Section 92.202 of the Section 1557 regulations similarly requires that covered entities 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 person with a disability. Section 92.8 requires each covered entity to 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, sex, 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). Additionally, § 92.9 requires training relevant employees on these procedures.

Integration, § 84.76

Recipients have a longstanding, affirmative obligation under the integration requirement of Section 504 to administer a program or activity in the most integrated setting appropriate to the needs of a qualified person with a disability. As the United States Supreme Court held in *Olmstead v. L.C.,* the unjustified segregation of persons with disabilities constitutes discrimination.[10]

This Section 504 final rule clarifies how to comply with this integration requirement and codifies that recipients have obligations to people with disabilities who currently receive services in the community and who are at serious risk of institutionalization.

The Section 1557 final rule contains a new obligation at **§** 92.207(b)(6) that explicitly prohibits recipients from having or implementing benefit designs that do not provide or administer health insurance coverage or other health-related coverage in the most integrated setting appropriate. That obligation also prohibits benefit designs that result in serious risk of institutionalization or segregation.

Revisions Made for Consistency with the Americans with Disabilities Act (ADA) and Additional Section 1557 Protections

The vast majority of recipients have been covered by the ADA since 1990. The Section 504 rule was updated to reflect these provisions, including by adding sections on an updated definition of "disability;" reasonable modifications to policies, practices, and procedures; illegal use of drugs; maintenance of accessible features; retaliation or coercion; personal devices and services; service animals; mobility devices; direct threat; accessibility standards; and defenses.

The Section 1557 regulations also contain several disability provisions, some of which were added for consistency with the ADA. Regarding accessibility standards applicable to buildings and facilities, § 92.203 prohibits discrimination against qualified individuals with disabilities because facilities are inaccessible or unusable by those individuals. The Section 504 regulation contains a similar provision on program accessibility regulations at §§ 84.21 - 84.23. As in §

[10] *Olmstead v. L. C.*, 527 U.S. 581 (1999).

84.68(b)(7) of the Section 504 regulations, § 92.205 of the Section 1557 regulations requires covered entities to make reasonable modifications to policies, practices, or procedures 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. Section 92.8 of the Section 1557 regulations requires covered entities to implement written reasonable modification policies and procedures. Section 1557 also contains detailed training and notice requirements at §§ 92.9-11.

Conclusion

This letter contains some of the obligations in the Section 504 and Section 1557 final rules. Health care providers are encouraged to visit the OCR Section 504 web page and the Section 1557 web page for additional information on their disability nondiscrimination obligations. While the disability nondiscrimination obligations of Section 504 and Section 1557 are similar, there are some deviations, and it is the responsibility of the recipient/covered entity to ensure that they comply with both laws.

We call your attention to these new requirements so that you can take steps to understand them and ensure that you are compliant before their effective dates so that you may avoid inadvertent discriminatory acts that result in enforcement actions by OCR. For the web content and mobile app accessibility and MDE requirements that will go into effect in two (2) and three (3) years' time, we encourage you to begin planning for their implementation as soon as possible.

OCR remains committed to ensuring accessibility for people with disabilities while informing covered entities of their obligations so they can voluntarily comply. OCR will continue to update its guidance documents and provide technical assistance and outreach whenever possible to advance these goals.

Sincerely,

/s/

Melanie Fontes Rainer

Director, Office for Civil Rights