

## Publications

# HHS Updates Regulations Implementing Section 504 of the Rehabilitation Act

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On May 9, 2024, the Biden Administration continued its push to update and modernize federal nondiscrimination protections by publishing [revised regulations](#) (the “Final Rule”) that amend the Department of Health and Human Services (“HHS”) longstanding rules under section 504 of the Rehabilitation Act of 1973. These rules prohibit entities that receive federal financial assistance (“FFA”) and Federal agencies from discriminating against individuals with disabilities. These rules are separate from the [new final rule](#) implementing section 1557 of the Patient Protection and Affordable Care Act’s (“ACA”) prohibition of discrimination on the basis of age, sex, race, or disability in health programs or activities that receive FFA. Both of these rules were published shortly after the Administration’s recent changes to the Americans with Disabilities Act (“ADA”) title II regulations, administered by the Department of Justice, to establish specific requirements and technical standards making the services, programs, and activities offered by State and local government entities accessible to the public through web and mobile applications.

HHS issued the Final Rule to reflect federal antidiscrimination laws like the ADA and the ACA, as well as to reflect other changes over the past nearly 50 years since the issuance of the initial section 504 rules. Similar to the [new section 1557 final rule](#), the Final Rule reflects the Biden Administration’s emphasis on integrated care for individuals with disabilities, in addition to recognizing technological advances.

## Who Is Affected?

Health providers, health insurers, and others that receive FFA from HHS are subject to this Final Rule.<sup>[1]</sup> Note that, in the preamble to this rule, HHS said that the definition of FFA for purposes of section 504 is narrower than for section 1557.

**GROOM INSIGHT:** ACA section 1557’s new final rule defines FFA to include grants, loans, and other types of assistance from HHS, as well as credits, subsidies, and contracts of insurance consistent with section 1557’s statutory text. In contrast, the Final Rule defines FFA to mean “any grant, cooperative agreement, loan, contract (other than a direct Federal procurement contract or a contract of insurance or guaranty), subgrant, contract under a grant or any other arrangement” by which HHS makes available funds, services of federal personnel, real and personal property—including transfers or leases of such property for less than fair market value or the proceeds from such transfers if not returned to the Federal government—and any other thing of value via grant, loan, contract, or cooperative agreement.

Like section 1557, section 504 has broad applicability, including providers, facilities, nursing homes, state and local human or social service agencies, and more. This alert will focus on the Final Rule’s impact on carriers. Entities that are subject to both section 504 and section 1557 should also note that section 504 extends to discrimination in employment, while section 1557 does not.

**GROOM INSIGHT:** Although there is considerable overlap between section 504 and section 1557, the implementing regulations for these statutes provide different obligations for accommodations. ACA section 1557 imposes ADA Title II requirements on its covered entities, meaning such entities must give primary consideration to the choice of aid or service requested by the person who has a communication disability. As a result, covered entities must honor the person’s choice of aid, unless it can demonstrate that there is another equally effective means of communication available or that the preferred means of assistance would result in a fundamental alteration or is an undue burden. In contrast, section 504 claims are governed by the same substantive standard of liability as claims brought under ADA Title III, which does not require covered entities to honor an individual’s choice of auxiliary aid. Instead, the requestor bears the burden of establishing that the offered accommodation is unreasonable.

## Compliance Date

The rule is effective on July 8, 2024. A covered entity’s size determines the extent of its obligations under section 504. The Final Rule adopts the definitions for “small” and “large” covered entities in HHS’s existing section 504 implementing regulations. Specifically, HHS defines a covered entity as “small” if it employs less than 15 employees and “large” if it employs 15 or more employees. Certain requirements, such as the web, mobile, and kiosk standards, have a delayed applicability date (2 years for large covered entities; 3 years for small covered entities).

## Summary of Changes

### *Discrimination in Medical Treatment*

In addition to section 504’s general prohibition on discrimination against individuals with disabilities, under the Final Rule, there is a general prohibition against discrimination in administration, criteria, and protocols related to medical treatment of individuals with disabilities, including allocation of scarce resources. The prohibition on discrimination in medical treatment should be read in conjunction with the general prohibition on discrimination against individuals with disabilities.

HHS recognized that clinical evidence on efficacy and effectiveness is relevant in determining whether a decision to provide (or not to provide) an individual with a disability with a particular drug or treatment was discriminatory.

### *Value Assessment Methods*

The Final Rule makes clear that value assessment measures or tools that discount the value of life extension for people with disabilities cannot be used to deny or afford an unequal opportunity to that individual with respect to eligibility or referral for, provision of, or withdraw of an aid, benefit, or service. Nondiscriminatory uses of value assessment methods are not prohibited.

HHS notes that section 504’s prohibition on the use of value assessment measures is broader than the Social Security Act’s limit on using “dollars-per-quality-adjusted-life-year (or similar measure that discounts the value of a life because of an individual’s disability)” (“QALY”) when the Patient Centered Outcomes Research Initiative develops coverage and reimbursement recommendations. Nonetheless, HHS says that the rule does not ban the use of QALYs.

## *Amended Definition of Disability*

HHS amended the definition of disability by adopting the ADA Amendments Act of 2008's definition. The term "disability" now will be construed broadly and in favor of expansive coverage. HHS also updated the definition to include long COVID and updated terminology. The Final Rule includes detailed definitions of key terms, including physical or mental impairment, major life activities, substantially limits (which is used to determine whether a given impairment sufficiently impacts a major life activity), and others. HHS noted, however, that it would not be possible to list all physical and mental impairments subject to the rule. As a result, covered entities should consider the included terms illustrative, not exclusive. As a result, HHS also stated that, when investigating claims of discrimination, the "primary objective of attention" should be whether discrimination occurred and not whether the individual at issue was disabled, noting that "the question of whether an individual meets the definition of 'disability' should not demand extensive analysis."

## *Reasonable Modifications*

HHS notes that covered entities are not required to fundamentally alter their programs or activities in order to comply with section 504, but that reasonable modifications to programs or services may nonetheless be required. This is true even if the covered entity is otherwise in full compliance with the requirements of other Federal health program statutes or rules. The Final Rule also explains that wearing masks or other infection mitigation measures may be reasonable modifications to avoid discrimination on the basis of disability.

## *Maintenance of Accessible Features*

Regulated entities must maintain, in operable working conditions, features of facilities and equipment that are required to be readily accessible to and usable by individuals with disabilities. Isolated or temporary failures would not violate section 504, but an individual with a disability may ask for a reasonable accommodation, if necessary, even if the failure is temporary. As an example, if an elevator was temporarily unavailable, it would be reasonable to accommodate an individual with a mobility disability by meeting on the ground floor or in a nearby building.

## *Integration*

The Final Rule "expands" the current section 504 integration mandate that requires regulated entities to administer programs and activities "in the most integrated setting appropriate to the . . . needs" of a person with a disability. HHS addressed concerns that some individuals with disabilities are best served by institutional settings designed to provide specialized care by noting that the Final Rule codifies case law and other federal guidance requiring the use of the most integrated setting most appropriate for the individual with a disability's needs. The preamble emphasizes that "the overwhelming weight of authority supports robust protection for individuals at serious risk of unnecessary institutionalization" and that covered entities have an affirmative obligation to avoid discrimination through isolation.

HHS also emphasized that the most integrated setting requirement applies to all covered entities without exception, including Medicare Advantage plans, Medicare Part D plans, PACE (Program of All-inclusive Care for the Elderly) programs, dual-eligible plans, Medicaid Managed Care organizations, and hospitals that receive FFA. In the preamble, HHS made clear that a covered entity could violate section 504 through reimbursement rates or network contracting, if these kinds of administrative decisions result in individuals with disabilities only being able to receive institutional services or services in segregated settings.

As a defense, covered entities may continue to argue that the most integrated setting would fundamentally alter the program and therefore should not be required. Whether a program would be fundamentally altered to provide the most integrated setting is a fact-specific decision, but "increased costs alone is not necessarily a fundamental alteration."

Covered entities' obligations under section 504 are separate and distinct from other federal civil rights obligations that apply, including those found in ACA section 1557, Medicaid, and the Social Security Act. As a result, compliance with other federal civil rights law would not necessarily be sufficient to demonstrate compliance with section 504.

## *Communications*

HHS says that the communications requirements adopted in the Final Rule are nearly identical to the communications requirements in the ADA title II regulations. Under the prior rule, small covered entities were not subject to the communication rules. Although the scope of the Final Rule expands to entities of all sizes that receive FFA, HHS believes that the vast majority of covered entities are already subject to ADA effective communication requirements.

## *Web, Mobile, and Kiosk Accessibility*

HHS updated the Final Rule to include new definitions relevant to web, mobile, and kiosk communications, including harmonizing certain definitions to align with Web Content Accessibility Guidelines (“WCAG”) 2.1. HHS promised technical assistance and guidance to covered entities as they come into compliance with these requirements and granted a delayed effective date for the web content compliance obligations of two or three years (depending on the covered entity’s size).

All entities are required to comply with WCAG 2.1 Level AA for web content and mobile apps, but small entities have three years to comply instead of the two-year compliance deadline for large entities. The Final Rule also provides certain exceptions from compliance (such as for archived web content). Entities may implement WCAG 2.2 Level AA as a substantially equivalent or greater level of accessibility to 2.1. Entities have an ongoing obligation to ensure that their websites, web content, and mobile applications comply with the Final Rule; however, there is an exception for preexisting (posted before the date the covered entity must comply with the Final Rule) social media posts. HHS believes that making these posts compliant may be very costly and provide little benefit because these kinds of communications are usually meant to provide then-current information that may be outdated and replaced quickly. Likewise, there is a limited exception for “conventional electronic documents,” such as PDFs, that are part of a covered entity’s web content or mobile apps before the compliance date.

**GROOM INSIGHT:** The exception for preexisting conventional electronic documents and the other exceptions (as well as the overall compliance requirements) parallel the new ADA Title II rules compliance exceptions. The exceptions for preexisting conventional electronic documents in both rules do not apply, however, if the documents “are currently used to apply for, gain access to, or participate in the [covered entity’s] programs or activities.” As a result, covered entities should carefully evaluate whether PDFs and other legacy documents remain in use for the covered program or activity.

Nevertheless, HHS reminds covered entities that making the content accessible when created is easier and less costly than remediation, and covered entities have a general obligation to meet section 504’s antidiscrimination requirements before (and after) the Final Rule’s effective dates.

Websites and mobile apps that a covered entity, or a third party on behalf of a covered entity, operates are subject to the Final Rule’s standards. This includes direct and indirect contracting and licensing that makes web content or mobile applications available. HHS is clear that a covered entity is responsible for making content accessible—including content made available to the public—even when the covered entity is not responsible for the design of the content, if the covered entity is using the content to provide a program or activity.

HHS notes that kiosks do not have the same deeply considered standards as WCAG 2.1 and medical diagnostic equipment (“MDE”), and as a result, when the technical standards are not applicable, a more general prohibition on discrimination will apply to the use of kiosks.

With respect to measuring compliance, HHS will not require 100 percent (or any other percent) compliance with WCAG 2.1 Level AA, but will instead focus on actual access. HHS recognizes that technical noncompliance may be identified, but technical noncompliance alone does not mean that a covered entity violated the Final Rule. Rather, HHS will look for whether any deviation from WCAG 2.1 Level AA affected access for an individual with a disability. Similarly, while a covered entity’s compliance may be nearly perfect, even a single instance of nonconformance could adversely impact someone with a disability, and HHS will consider that impact in assessing compliance.

When evaluating compliance, HHS (through its Office for Civil Rights) may review covered entities’ policies and procedures, including testing processes and remediation efforts. HHS declined to adopt a window of time during which a non-compliant covered entity could come into compliance; however, HHS provided a two or three-year delayed effective date for these requirements (depending on the size of the covered entity).

If a covered entity can demonstrate that any non-conformance with WCAG 2.1 Level AA had a “minimal impact” on access for individuals with disabilities, the covered entity will be deemed to have met its obligations under the rule. HHS reminded covered entities that this flexibility is intended to be rare and not an excuse to avoid WCAG 2.1 Level AA compliance altogether and that this provision of the rule does not prevent individuals from filing complaints or agencies from conducting compliance reviews. In addition, to demonstrate “minimal impact,” HHS expects a covered entity to demonstrate that its non-conformance “would not affect” individuals with disabilities and the lack of, or small number of, complaints would not meet this standard. The Final Rule, and the preamble to the Final Rule, go into much greater detail about what the phrase “would not affect” means in this context.

## *Enforcement*

In response to concerns that the proposed rule did not have sufficient enforcement mechanisms, HHS noted that the Final Rule requires HHS to investigate complaints and conduct periodic compliance reviews even absent complaints. HHS will initially work toward voluntary compliance, as it has in the past, but may refer matters to the Department of Justice to secure compliance.

## *Data Collection*

Covered entities are required to keep compliance records, including data showing the extent to which individuals with disabilities are beneficiaries of and participants in federally assisted programs so that HHS can determine compliance. The Final Rule does not require covered entities to collect and report this information to HHS, but HHS may request it on a case-by-case basis.