

To: The Department of Health and Human Services  
From: The Ability Center of Greater Toledo  
Date: November 13, 2023

RE: Section 504 of the Rehabilitation Act: Discrimination on the Basis of Disability in Health and Human Service Programs or Activities

Docket ID Number HHS-OCR-2023-0013

Dear Director Fontes Rainer:

Thank you for the opportunity to comment on the Department's proposed Section 504 regulations. Overall, we support and applaud the work to update Section 504 and look forward to seeing them go into effect. We also invite any future questions or opportunities for feedback.

**A. The Ability Center of Greater Toledo supports updating the regulations of the Department of Health and Human Services that implement Section 504 of the Rehabilitation Act.**

Overall, The Ability Center supports updating the regulations enacted by the Department of Health and Human Services to implement Section 504 of the Rehabilitation Act of 1973. Section 504 was the very first statute to make it unlawful to discriminate against people with disabilities in services and activities.<sup>i</sup> It was remarkable that Section passed at all – the law was passed only with intense pressure and organizing by people with disabilities themselves.<sup>ii</sup> Even more difficult was getting, at the time, the Department of Health, Education, and Welfare to promulgate regulations to allow the implementation of the law.<sup>iii</sup>

Now, fifty years later, the landscape for people with disabilities and the landscape of our country has changed due to advancing technology and increased community-based living. Rather than living out their lives in institutions, many more people with disabilities are living in the community, a statistic only increased by Aging citizens who wish to Age in Place. Yet, many medical professionals still have not adjusted to providing community-based care for individuals with disabilities. While HHS regulations have been updated in small ways since they were signed, we support re-evaluating and updating these regulations as well as the issue areas that HHS has identified.

In particular, the past five years of the COVID-19 Pandemic have shed light on the rampant discrimination that still takes place in health care settings in the United States. Please accept our comments on the proposed updates below.

**B. Who is The Ability Center?**

The Ability Center of Greater Toledo is a Center for Independent Living serving seven counties in NW Ohio. Together, we will work to make our community the most disability friendly in the nation by increasing independence for people with disabilities, discovering true passions, and changing the community's perception of disability.

### C. General Comments

- a. **The Ability Center supports updating the language of the regulations to reflect modern, person first language without using outdated terminology.**

The Ability Center is supportive of and appreciates the department's update throughout the new version of the rule to person-first language. When outdated language such as "handicapped" is used to describe people with disabilities in regulations, those outside of the disability community sometimes become confused by which language is appropriate. Additionally, the fact that the law uses outdated language lends legitimacy to terms that many find offensive. We support the elimination of the word "handicapped" and the amendment to using person first language throughout the proposed rule.

### D. Access to Healthcare: Medical Treatment Questions

The Ability Center is supportive of proposed section 84.56 and the explicit bases for discrimination laid out in that section of the proposed rule.

- a. **Section 84.56(a) should specifically prohibit a "denial" of health care. Many providers still refuse to provide care to individuals with disabilities solely because of their disability.**

We recommend that the blanket anti-discrimination provision in Section 84.56(a) be amended to include the word "denial," so that it reads, "No qualified individual with a disability shall, on the basis of disability, be subjected to discrimination in medical treatment under any program or activity that receives Federal financial assistance, including in the *denial*, allocation, or withdrawal of any good, benefit, or service."

The Ability Center sees a need, especially since the COVID-19 Pandemic, to specifically highlight disability discrimination in medical care based on the allocation or withdrawal of any good, benefit, or service. However, the classic case of discrimination against people with disabilities is still a *denial* of medical care. One of the first U.S. Supreme Court cases involving a violation of the Americans with Disabilities Act involved a dentist who refused to treat an HIV positive patient.<sup>iv</sup> While the Supreme Court found this to be unlawful discrimination under the ADA, today medical providers still refuse to treat a person with a disability on the basis of their disability.<sup>v</sup>

A recent study published in the journal of Health Affairs found that, even today, medical providers reported denying care to people with disabilities or attempting to discharge people with disabilities from their practices because they found them too burdensome to treat or did not have the correct equipment.<sup>vi</sup> Study participants even admitted that they found ways to deny patients with disabilities without stating explicitly that they would not accept them as a patient due to their disability.<sup>vii</sup> Thus, we recommend that the blanket anti-discrimination provision found in Sec. 84.56(a) include "denial of care" specifically in its list of unlawful actions.

- b. While the wording of 84.56(B)(2) seems appropriate for the type of discrimination highlighted here, we offer several examples of this type of discrimination for HHS to consider when evaluating how to draft this rule.**

*Medical Treatment Question 1: We recognize that the line between disabilities may in some cases be more difficult to draw than in these examples, and we welcome comment on the best way of articulating the relevant distinctions.*

Proposed Rule 84.56(B)(2), states, “Where a qualified individual with a disability or their authorized representative seeks or consents to treatment for a separately diagnosable symptom or medical condition (whether or not that symptom or condition is a disability under this part or is causally connected to the individual’s underlying disability), a recipient may not deny or limit clinically appropriate treatment if it would be offered to a similarly situated individual without an underlying disability.”

The wording of this rule seems appropriate, but The Ability Center would like to offer the following examples of this type of discrimination to help inform HHS’s drafting of the rule. The main terms of art that will be at issue when this rule is enforced will be “separately diagnosable symptom or medical condition” and “clinically appropriate treatment.” In order to understand this rule, a medical provider will need a clear picture of the word “underlying disability” as well. It would be helpful for HHS to state explicitly that decisions to refuse treatment for a separate diagnosable symptom or medical condition cannot be made on the basis of the assumption that a disability will prevent a person from following through with treatment or assumptions about a person’s quality of life after treatment.

The four examples of discrimination under this provision that are most familiar are the refusal to give a person with underlying disabilities an organ transplant; the use of specific conditions as a reason to refuse treatment in scarce allocation of resources policies on the assumption; the failure of physicians to aggressively treat separate, life-threatening conditions for those infected with HIV<sup>viii</sup>; and the decision not to extend the life of a person with significant disabilities after a sudden traumatic event like a car accident. The literature shows that each of these takes place due to an unjustified assumption about the quality of life, or the life worth, of a person with significant disabilities or an assumption that a person could not possibly follow a particular treatment regime due to an intellectual disability or other underlying condition.

- **Denial of Organ Transplants**

It is well documented that individuals with disabilities are less likely to receive donated organs due to presumptions about follow through or quality of life. In the past, organ transplant guidelines have made disability a criterion on which to deny a patient. Today, some doctors and organ transplant centers still consider disability, and particularly mental health disabilities, to be a relative or contraindication to organ transplant.<sup>ix</sup> Primarily, organ transplant centers will refuse to evaluate a person with a disability as a candidate for transplant or refuse to place a person with a disability on the national organ transplant waiting list.<sup>x</sup> This is because many physicians still view HIV and AIDs, as well as intellectual, developmental, or psychiatric disabilities, as relative or absolute contraindications to transplant.<sup>xi</sup> When they have been surveyed, transplant centers

cite assumptions about quality of life; concerns regarding compliance or long term self-care, financial concerns, and the functional prognosis of the delay itself.<sup>xii</sup>

- **Denial of Medical Treatment for a Separate Diagnosable Condition**

Likewise, there are recorded examples of individuals with disabilities who have been denied other medical treatment due to these assumptions. In 1991, the Journal of American Medical Association published the results of a survey of health professionals involved in the care of critically ill newborns at six hospitals in New York City. The survey was designed to investigate beliefs about appropriate management for a series of hypothetical infants, some at risk for or infected with HIV. In the results, a significant number of those polled indicated that they would be less likely to recommend aggressive treatment of a life-threatening condition for a newborn infected with HIV than they would if the infant suffering the life-threatening condition had no known HIV risk.<sup>xiii</sup>

The survey specifically measured how respondents' treatment recommendations for infants with life-threatening conditions like chronic kidney failure would vary depending on whether the infant 1) suffered from one of a number of genetic conditions; 2) was at risk for HIV infection; 3) was known to be HIV infected, or 4) had no genetic condition or known HIV risk.<sup>xiv</sup> Responses showed that a significant number of physicians would not recommend aggressive treatment. For example, in the case of an infant with duodenal atresia, 99.6% of the respondents would recommend corrective intestinal surgery for a full-term infant with no other concurrent conditions; and 75% would recommend surgery for an infant infected with HIV.<sup>xv</sup> While this study specifically concerned HIV, this practice is generalized to those with disabilities.

During the Pandemic, advocates also discovered that many scarce allocation of resources policies drafted for hospitals specifically mentioned a disability as a reason to deny medical treatment in favor of palliative care. Simply because a person had been diagnosed with a particular disability, they would have been found ineligible for treatment if treatment resources became scarce.

In Alabama, the Department of Public Health's first iteration of triage guidance excluded patients with "severe or profound mental retardation," "moderate to severe dementia," and "severe traumatic brain injury" from receiving mechanical ventilation if demand exceeded supply.<sup>xvi</sup> In Utah or Louisiana, a person with cystic fibrosis could have been denied a ventilator.<sup>xvii</sup> Other states denied drafted protocols that would have denied access to oxygen dependency, mental illness, and HIV.<sup>xviii</sup> While doctors were forced to make difficult decisions during this time due to an impending lack of medical resources, discrimination occurred because the decision making used categorical exclusions rather than individual assessments regarding the effectiveness of treatment.

- **Denial of Life-Saving Treatment**

Finally, there is evidence that people with disabilities can be subjected to abusive organ procurement practices because their "death would mean more to the people around them than their life."<sup>xix</sup> In the initial phase of an injury or a serious exacerbation of a chronic or progressive

condition, healthcare decision making that could lead to death may be under consideration.<sup>xx</sup> In one well-known example, a woman with a history of depression who had overdosed on a toxic cocktail of drugs was declared brain dead and was on the operating table being prepared for organ donation when she woke up.<sup>xxi</sup> The hospital missed many signs that her brain was still functioning.<sup>xxii</sup>

While plaintiffs have filed lawsuits to address these questions, the state of the current law -- whether a denial of medical care for separate conditions based on unjustified assumptions, and without an individualized assessment, violates the Rehabilitation Act and Americans with Disabilities Act -- is far from clear. Many physicians assume that, given the subjective nature of these decisions, disability civil rights laws may not be applicable.<sup>xxiii</sup> Many of the high-profile cases regarding organ donation, allocation of resources, and disability rights in medical care have involved media attention, or administrative enforcement, rather than court decisions. It will be helpful for HHS to clarify this form of discrimination.

- c. Examples of discriminatory treatment also involve assumptions about reproduction; attempts to “cure a disability”; referrals to institutional settings; and accepting the decision making of a third-party even when an adult with a disability is his or her own guardian.**

*Medical Treatment Question 2: The Department seeks comment on other examples of the discriminatory provision of medical treatment to people with disabilities.*

The Department mentions that “Reproductive health care for those with intellectual disabilities is a large area of concern for Section 84.56(B)(3). Doctors may prescribe forced sterilization for women with intellectual disabilities or forced birth control or abortion due to assumptions about fitness to parent.”

This section may also address risky procedures that doctors would not prescribe for others due to the risk based on the perceived value of “curing a disability” justifying the risk of a procedure.

Finally, this section should address medical providers’ decision to refer a person to an institutional setting as part of treatment. A medical provider should only refer a person to an institutional setting based on an identified medical need such as rehab from a particular condition. A medical provider should not refer a person to an institutional setting based on unjustified assumptions that a person’s quality of life will be better in an institutional setting rather than in the community.

- d. HHS regulations need to protect an adult with a disability’s ability to make their own choices about medical treatment. Where that is not possible, decisions about medical treatment should be made through the same channels that they would be made by a person without a disability. Also, the Department should substitute “legitimate” with an individualized assessment based on objective scientific evidence.**

***Medical Treatment Question 3: The Department seeks comment, including from health care professionals and people with disabilities, on the examples described in this section, whether additional examples are needed, and on the appropriate balance between prohibiting discriminatory conduct and ensuring legitimate professional judgments.***

Proposed Rule 84.56(B)(2), states, “Nothing in this section requires the provision of medical treatment 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.”

In this particular rule, The Ability Center is concerned with the interpretation of the word “legitimate.” The literature, as well as individual provider understandings, often believe that their reasons for denying medical are legitimate, even if they are based on stereotypes – this person won’t live as long as another patient; this person won’t be able to follow through with a treatment regiment, this person’s quality of life is so poor that they would not want their life extended.

We recommend that this exception have a more detailed legal test -- regulations must establish a standard that medical decision- making regarding denial of treatment must be based on an, “individualized assessment based on available objective evidence”<sup>xxiv</sup> and allow for reasonable modifications in any assessment process used to determine a particular outcome.<sup>xxv</sup>

Thus, the rule would read, “Nothing in this section requires the provision of medical treatment where the recipient has *made a treatment decision using an individualized assessment based on available objective, scientific evidence* or where the disability renders the individual not qualified for the treatment.”

The rule should also specify that reasonable modifications should be made to any assessment process where necessary because of a disability.

Finally, this section needs to ensure that people with disabilities still have the ability to weigh the risks and opt into risky procedures when it is their choice. A medical professional may think that he or she has the judgment to determine whether or not the risk of a certain procedure is worth the potential results. However, if the provider has no background in disability or knows very few persons with disabilities, the provider may question the judgment of an individual with a disability or his or her guardian. In many instances, providers do not believe that a person with a visible disability like cerebral palsy can make their own decisions, even if they are their own guardian.

Even though it is necessary to have a section that sets up the limits of what constitutes discrimination, a provider could use this section to deny medical treatment to a person who has a different perspective than the provider regarding the risks.

***Medical Treatment Question 4: The Department seeks comment from all stakeholders on the risks and benefits of the proposed regulatory choices that the Department has put forth in this section.***

The Ability Center is supportive of the rules that the Department has drafted. These rules address current situations where medical providers still make decisions based on unjustified stereotypes based on disability – in denial of care, allocation of resources, and withdrawal of medical treatment. This is a necessary step in eliminating discrimination in the medical system on behalf of disability.

The main risk of this section is clearly separating a “legitimate” reason for denial of medical treatment from subjective, unconscious bias about disability. The Ability Center participated in a workgroup that created Scarce Allocation of Resources policies during the COVID-19 Pandemic for our region. When workgroups came together to create non-discriminatory scarce allocation of resources policies as part of the COVID-19 Pandemic, each physician had a different idea of whether certain, identified disabilities should be included in the category for palliative care rather than active treatment. Often, physicians treating those, for example, who had end stage cancer or renal disease, would object to those disabilities being identified for palliative care because of personal experiences with the length of their patients’ lives after diagnosis, while physician with different specialties thought it was reasonable to identify patients with those specific disabilities in a policy to allocate resources. The very lack of experience with those particular patients made subjective decision making and assumptions risky.

The Americans with Disabilities Act clearly prevents discrimination in medical treatment on the basis of disability, such as in *Bragdon v. Abbot*.<sup>xxvi</sup> However, when it is not clear that the discrimination is on the basis of a disability, it is more difficult to pull out a clearly defined rule from the law. This section needs to address the bias and unconscious assumptions of physicians and other care professionals clearly while still balance the need for objective, science-backed evaluation.

***Medical Treatment Question 5: The Department also seeks comment on whether the term “medical treatment” adequately encompasses the range of services that should be covered under this nondiscrimination provision.***

In order to make this broader and more encompassing, the Department could use the term “medical services,” or “goods, benefits, or services,” as it is used initially in the proposed rule.

In short, The Ability Center is supportive of the Department’s update to rules regarding denial of care, especially because the current state of the law does not provide a clear rule. We recommend taking into account the major examples of discriminatory medical care found in the literature and case law; specifying that a “denial” of goods, benefits, or services is a type of discrimination; and ensuring that any exception is based on an individualized assessment based on objective, scientific evidence and takes reasonable modifications into account.

## **E. Value Assessment Rules**

As a Center for Independent Living, The Ability Center will refer to and adopt in full The National Center of Disability, Equity, and Intersectionality’s comments on the issue of Value Assessment because they have more direct experience in the area of particular assessments used for treatment.<sup>xxvii</sup>

## **F. Child Welfare and Custody**

- a. The Department should enact rules seeking to ensure that, as much as possible, children with disabilities stay with their families and that parents with disabilities keep their children.**

*Child Welfare Question 1: “The Department seeks comment on additional examples of the application of the most integrated setting requirement to child welfare programs and welcomes comments on any additional points for consideration regarding integration of children with disabilities in child welfare contexts.”*

The most integrated setting for a child with a disability is with their family or in another home and community-based setting. A child should never be denied a placement at home or in a home and community-based setting because of a failure of a child welfare agency or other governmental agency to provide services in the most integrated setting appropriate to their needs.

Decisions to place a child in a segregated setting should be a last resort and should be based on an individualized assessment of that child’s needs as opposed to unjustified stereotypes or generalizations. The Department must require individualized assessments based on current medical knowledge and the best available objective evidence about the appropriateness of a placement. The child’s personal preferences must be taken into consideration as well.

*Child Welfare Question 3: The Department seeks comment on how agencies would implement these referral procedures, ensure that service providers use the methods described, and prohibit the use of IQ alone as the basis for a parenting assessment.*

Discrimination against parents with disabilities is rampant in the child welfare system. The Ability Center receives calls on a regular basis where a parents’ disability – physical disabilities, sensory based disabilities, and intellectual disabilities – are the sole basis for removing a child from a parent based on outdated stereotypes of a person with a disability’s fitness to parent. The Department should prohibit the use of IQ along as the basis for a parenting assessment.

Child welfare agencies need to be aware of the Home and Community Based Services and support in their states, as well as other supports that are available to parents with disabilities in order to parent. For example, blind parents have reported having their fitness to parent questioned because they cannot drive a car or “read” their child’s homework. However, they are able to use public transportation and screen readers to accomplish these tasks.

One way of ensuring this is to require child welfare agencies to take into account the reasonable modifications, supports, and services available to parents with disabilities in evaluating their fitness to parent. Recently, The Ability Center helped the state of Ohio adopt a custody discrimination law that prohibits child welfare agencies from removing children from their parent’s custody without evaluating what reasonable modifications and supportive services are available to assist them. Ensuring that welfare agencies are taking reasonable modifications and



supportive services into account is the only way to ensure that parents with disabilities are free from discrimination.

Additionally, all child welfare processes must be accessible. For parents with disabilities to understand what is going on in a court case or child welfare procedure, the processes and procedures must be made accessible to them.

Child welfare and parents with disabilities are important areas for The Department to regulate – areas where unjustified assumptions about disability are regularly made and the law is not always clear. The Ability Center is highly supportive of updates to rulemaking in this area.

### **G. Web and Other Internet Access**

- a. The Department should ensure that web and internet accessibility guidelines are specific, measurable, and cover as much technology access as possible to ensure that all technology is accessible to individuals with disabilities even as technological tools are updated over time.**

#### ***Q1: Definition of “Conventional Electronic Documents.”***

**The Department of Justice should expand the proposed definition of “conventional electronic documents” to include all file types as documents covered under title II of The ADA to ensure all formats used to consume, create, and share web-based information are made accessible to people with disabilities.**

Inaccessible web content means that people with disabilities are denied equal access to information. Inaccessible files/documents can exclude people just as much as steps at an entrance to a physical location.<sup>xxviii</sup> File types and documents with inaccessible features can limit the ability of people with disabilities to access a public entity’s programs, services, and activities through the website. Therefore, it is imperative the Department of Justice not only ensure that the most commonly used file types and documents are accessible, but that they account for as many forms of documents and file types as possible to ensure whatever form a person with a disability can utilize to access a public entity’s programs and services are made accessible.

Additionally, part of the reason for this update is that web and other technology is constantly changing. Most recently, our society is trying to adjust to the increase in virtual meetings, such as zoom meetings, and the introduction of AI software like ChatGTP. Five years ago, these technologies may not have been on the radar for accessibility review. This rule needs to apply to updated technologies as well as current technologies.

#### ***Q2: Definition of Kiosks***

**The Department of Health and Human Services should consider adding the primary/most common tasks that kiosks used in healthcare settings are intended for to the definition of kiosks in 84.10.**

The proposed rule states, “Kiosks are self-service transaction machines made available by recipients at set physical locations for the independent use of patients or program participants in health or human service programs or activities.”

Though this definition does define kiosks in terms of their prevalent use in health or human services programs, the definition itself does not explicitly state the common types of tasks that kiosks utilized by healthcare providers are intended to perform. Individuals with disabilities who have never used a kiosk in a healthcare setting before may need a more robust definition to be able to determine beforehand if assistance or accommodations are needed for them to use the kiosk. Therefore, we recommend adding the primary functions of kiosks in health settings to the definition to more accurately convey the purpose of this technology. Primary tasks that kiosks used in healthcare settings commonly perform are as follows:<sup>xxix</sup>

- Checking in/out for appointments;
- Providing information for the receipt of services;
- Procuring services;
- Measuring vitals;
- And performing other services without interacting directly with recipient staff.

### ***Q3: Refinements to the Definition of “Web-Content.”***

**The Department of Justice should ensure that refinements to the definition of web content ensure that success criteria is Robust AND Specific enough to ensure the usability of web content by all people with disabilities.**

The Ability Center supports the WCAG definition of web content. Web access requirements should also ensure that web standards include being Perceivable, Operable, Understandable, and Robust.

The WCAG standards have 12-13 guidelines organized under 4 principles: Perceivable, Operable, Understandable, and Robust. In terms of the robust criteria, one suggestion is to ensure that though the content should be robust enough that it can be interpreted reliably by a wide variety of users, it should also be specific enough not to become a “catch-all” for any given requirement.

In addition, the WCAG standards should include in their operable success criteria interoperability requirements to ensure that a mobile app does not disrupt a device’s assistive technology.

#### ***Q4: Technical Standards or Performance Standards other than WCAG 2.1***

The U.S Access Board’s Section 508 standards include additional requirements applicable to mobile apps that are not in WCAG 2.1.<sup>xxx</sup> The U.S Access Board’s Section 508 standards ensure that ICT they develop, procure, maintain, or use allows employees and individuals with disabilities who are members of the public to have access to and use of information and data.<sup>xxx</sup> Including the U.S Access Board’s Section 508 Standards will ensure that the Department of Justice is accounting for all changes to web-based content that evolves alongside technology. The rapid pace at which technology changes presents unique challenges because as technology changes so must the formats used in those technologies. Therefore, including standards such as Section 508 will enable the U.S Department of Justice to ensure that accessibility remains a top priority as technology increases and advances within the public sector.

#### ***Q5: How Accessible are Small Public Entities’ Web Content and Mobile Apps Currently?***

The Ability Center runs a program that gives technical assistance to local governments in our region regarding compliance with the ADA. Generally, local governments do not have very accessible web content and mobile apps, especially small public entities, which are not likely to have compliance officers ensuring access to web content. Even after The Ability Center gives these public entities tools to check the accessibility of their web and app content, they often will not update their content to make it accessible because of a lack of a designated person to ensure that this takes place.

Otherwise, there are two major reasons why public entities’ websites are inaccessible to people with disabilities. First, awareness of standards and regulations encouraged or required by the ADA is still limited, despite it now being 33 years since it became law. Second, most businesses are concerned with the “cost” of accessibility features; and thus, just do not comply. There are indeed instances where small public entities may be experiencing a true financial burden to make their website accessible, such as rural community business owners with limited internet access and limited funds. However, on average it will cost a company between \$1500 to \$5000 to make a website fully compliant with the WCAG Standards from the ground up.<sup>xxxii</sup> Most small public entities will have simpler websites that do not require that level of work, and so those estimates only pertain to large public entities with extraordinarily complex websites.

The smaller the public entity and the smaller the pool of users engaging with their apps and social media means less feedback on accessibility issues of the web-based content. Not surprisingly then, small businesses have found themselves sued at an unprecedented rate in the last several years over their websites, social media, and apps being inaccessible to people with disabilities.<sup>xxxiii</sup>

The request for comments stated: “The Department has heard that when these small entities develop or maintain their own websites, they often do so with staff or volunteers who have only cursory knowledge of web design and use manufactured web templates or software, which may create inaccessible web pages.” Web content needs to begin with templates that are accessible to begin with, and the ADA Standards and guidelines need to be widely taught as essential to the development of a website. Perhaps the fact that most enforcement is against public entities and places of public accommodation, rather than web developers, fails to address the core issue.

Small entities are a hub for local community members, and so are their web pages, social media accounts, etc., It is highly likely that most small entities have web content, apps, and social media applications that are inaccessible but easier to fix than large entities for these reasons.

#### *Q6: WCAG Version or Conformance Level for Small Entities or a Subset of Small Entities*

**Small Government entities should comply with WCAG 2.1 standards in the same manner that other larger governmental entities comply with the standards. To do so, funding sources to alleviate financial burdens for small government entity web content should be made more readily available for accessibility improvements.**

Small Government entities may experience some financial burdens due to lack of overall funding available to update web content for accessibility. Though small Government entities may experience greater difficulty when it comes to the financial side of updating for accessibility, they must still conform to the WCAG 2.1 standards, as would a large Government entity, to ensure that all people with disabilities can access their web content. It is important to take into account the financial expenditures of small Government entities, since they historically have less access to funds than larger entities. The Department of Justice should consider financial incentives for these small entities earmarked for accessibility improvements to web content, to alleviate monetary burdens and ensure that both small and large entities have the funding available to perform the necessary accessibility improvements.

#### *Q7: Public Entities and Social Media Platforms*

**The U.S Department of Justice should adopt the Federal Social Media Accessibility Toolkit to better understand how to address the barriers to access that individuals with disabilities experience while attempting to access or use social media.**

The U.S Department of Justice should adopt the Federal Social Media Accessibility Toolkit<sup>xxxiv</sup> to better understand how to address the barriers to access that individuals with disabilities experience while attempting to access or use social media.

Government entities are increasingly using social media to engage with citizens, share information and deliver services more quickly and effectively than ever before. But as social

content, data and platforms become more diverse, agencies have a responsibility to ensure these digital services are accessible to all citizens, including people with disabilities.

Members of the public use information provided by public Government entities to gain knowledge on programs and services available to them, and to share the information with their social media contacts. If the content is not accessible, individuals with disabilities' ability to share the content with their social media contacts is severely limited, leading to less awareness of services that the Government entity provides. Specific barriers that people with disabilities encounter when attempting to access public entities' services via social media varies greatly. Some of the most common barriers experienced are as follows:<sup>xxxv</sup>

1. Lack of closed captioning;
2. Lack of alt-text;
3. Lack of headings;
4. Font size, contrast, and choice to change font and contrast;
5. No keyboard-only access;
6. Moving targets;
7. Animations;
8. Pop-ups;
9. Button size.

Governments need to have consistent, accessible standards to ensure social media platforms are accessible. Thus, the Department of Justice should use the Federal Social Media Accessibility Toolkit to create enforceable regulations.<sup>xxxvi</sup>

### ***Q8: Mobile Apps***

One way the government is working to improve the way they relay information to citizens is by developing mobile apps. With mobile apps, government agencies can relay important information such as emergency alerts or special news bulletins quickly and easily.

Locally, our government has an app available for everything related to its customer service department. So, a local app will send out emergency alerts or bulletins, but it is also being used to upload pictures and report issues with sidewalks or other government services. In the future, apps will likely be used to pay for government services, like water bills, and watch hearings or other local government action. Mobile apps need to contain accessible text, photos, procedures for uploading, and accessibility in streaming video.

According to a survey conducted by Diamond, only 35% of iOS and 29% of android apps, that require payment, exhibited basic accessibility compliance. Because paid apps likely have fewer users, they receive less feedback on how to improve accessibility. Therefore, many of the apps that require subscriptions or in app payments, are likely to be in some way not accessible to

individuals with disabilities. The Diamond report revealed four common failures and oversights that developers of mobile apps should be wary of in app design. They are as follows:<sup>xxxvii</sup>

- **Phone Orientation:**

Being able to switch phone orientations from portrait to landscape easily is crucial for all mobile app users, especially those with disabilities.<sup>xxxviii</sup> If a person with a disability cannot orient their phone to the most comfortable position for them, they likely will experience issues accessing the app.

- **Text Re-sizing**

Users with disabilities generally have their phones set in the precise accessibility settings needed individually. A genuinely accessible app would transfer users' preferred visual settings to app usage.

- **Alternative Text for Images**

According to Diamond's report, about 50% of paid iOS and 75% of paid Android apps lacked alt text features.<sup>xxxix</sup> For an app to be truly accessible, it must label images with image descriptions so that users who are blind or of low vision can comprehend the content. The same goes for adding captions and descriptions to videos found in-app.

- **Headings for Screen Readers**

According to Diamond's report, only 50% of paid iOS apps and 10% of paid Android apps had accessible headers.<sup>xl</sup> A screen reader is an assistive device used by users with visual impairments to access the internet. It processes and reads information aloud to the user. For screen readers to know what they're reading, they rely on website and app coding cues. Therefore, when there is no heading available, the individual using a screen reader may lose out on important information needed to understand the web content.

### ***Q9: Appropriate Accessibility Standards for Mobile Apps***

**The U.S Department of Justice should adopt Section 508 requirements alongside WCAG 2.1 Level AA Standards to ensure that mobile apps are accurately improved for accessibility.**

The U.S Access Board's Section 508 requirements includes additional requirements applicable to mobile apps that are not in WCAG 2.1.<sup>xli</sup>

When technology changes, accessibility features will need to be updated. Therefore, the U.S Department of Justice can adopt the U.S Access Board's Section 508 requirements alongside the WCAG Standards to ensure accessibility issues are accounted for as technology advances. This will streamline the process by including requirements for mobile applications that WCAG

Standards lack and catch accessibility issues that can be avoided when new technology and software emerges.

### *Q10: Compliance Date and Small Public Entities*

#### **Small and Large Public Entities Have Had Over 30 Years to Comply with the ADA; and Therefore, the U.S Government Should Make Funds Available to Small Public Entities to Come into Compliance Alongside Large Public Entities.**

From their own admission, public entities are concerned about costs because they think they will need to hire a web specialist on accessibility to make their website accessible. However, from their comments, they are already using web developers or a template to create a website.<sup>xliii</sup> They simply need to use a web developer or template that knows how to make a website accessible.

Hopefully, one of the effects of the new regulations will be that every web developer knows how to make web content accessible, and every template is also accessible. Accessibility does not require more talent or specialty than simply creating a website – web developers just need to educate themselves on the accessibility standards. State and local governments will simply need to do their regular website maintenance with developers that know about accessibility.

### *Q11: Compliance Date and People with Disabilities in Rural Communities*

#### **The Department of Justice Should Adopt the Proposal of Three Years for Compliance of Rural Communities and Create Financial Incentives to Alleviate Costs**

The Ability Center supports the proposed three-year compliance period for rural communities as well as financial incentives to alleviate costs. Like physical structures, even rural communities must update their websites periodically to ensure that they are up to date. Three years is plenty of time to ensure that those updates meet accessibility guidelines.

As a Center for Independent Living, we understand the unique barriers that individuals living in rural communities encounter in comparison to their urban counterparts. However, 33 years have passed since the ADA became law, and people with disabilities in rural communities, due to lack of resources and funding, experience greater barriers to accessing their communities than non-rural communities; including web-based content about local programs and services. Three years, as proposed, would give rural communities enough time to gather resources and organize systems to come into compliance; however, we urge the Department of Justice to create financial incentives for rural communities in an effort to ensure that when updates to accessibility are complete, both large and small entities will not have been financially burdened by the process.

### *Q15: Compliance Date and Live-Audio Content*

**The U.S Department of Justice should require all small and large entities to have live-audio content available for all web content to be streamed via the internet one year after issuing the rule.**

Technology to enable live-audio content/captions comes in many forms. The two most common forms are through automated devices and software (AI) and using a live captioner. This technology is readily available, comes in different forms of cost, and is even utilized by media applications such as zoom every time live captions are enabled. For these reasons, three years to come into compliance with live audio content is too long of a time frame. Individuals with disabilities experience barriers to participating in online government sessions and in receiving news related information when public and governmental entities continue to not comply with live-audio content/captions.

In Ohio, our General Assembly sessions continue to not have live-audio content/captions despite numerous efforts by our organization to ask them to do so. Especially since COVID moved things in a virtual direction, The Ability Center has heard from multiple disability consumers who want to watch the Ohio channel but cannot understand what is going on without live captioning.

One year should be enough time for most entities to enable services that provide live-audio content. In cases of rural communities that are incredibly isolated and in need of longer preparation times, the Department of Justice could allow for an extension.

#### *Q16: Types of Live-Audio Content*

**All forms of information to be live streamed by small and large public entities must have live-audio content/caption options for individuals who are blind, of low vision, deaf, or hard of hearing regardless of the type of content.**

The types of live-audio content that large and small entities post can vary greatly. Some areas where live-audio content should always be available are as follows:<sup>xliii</sup>

1. News blasts;
2. On the ground reports;
3. Government sessions,
4. Court hearings;
5. Notices of sales, availability of product, availability of services, and changes to rules, regulations, standards, of an entity;
6. Notices of public comment via virtual sessions;
7. And all other media content used for the purpose of live streaming.



The inability of entities to provide live-audio captions when live streaming media/web content continues to be a major barrier for individuals with disabilities who want access to real time information as it comes in like the rest of the public. For example, the State of Ohio broadcasts the hearings and committee meetings of the General Assembly members but does not have live-audio content enabled. Instead, they add captions after the fact. Therefore, individuals who are blind, of low vision, deaf, or hard of hearing cannot watch ANY of the sessions live as the rest of the public does, or at least cannot do so without great difficulty.

There are many forms of technology that provide live-audio content/captions. The technology ranges in price, depending on what is needed to enable the content and what technology the user is engaging with. AI powered closed captioning software can be embedded in a software such as zoom, or it could be purchased separately for use in broadcasts. In addition, most webcasting and live video streaming platforms provide a method for streaming a real-time captioning feed within the platform's user interface.<sup>[2]</sup> Any of these methods could be utilized by both small and public entities to ensure they always have live-audio content/captions on all web-based information they share, create, or procure.

While it is fine for local governments to use AI and automated captions for general meetings open to the public, local governments must also be aware of their requirements to provide reasonable modifications and auxiliary aids and services where necessary that are individualized to a person's needs. For example, for some individuals with disabilities, AI generated captions may not be thorough enough to give a clear sense of what is happening at a meeting, and a particular person may need to request CART, or live captioning, to follow along. In addition to having a set standard for accessibility, governments must be aware of their requirement to provide individualized access as well.

### **A. Accessible Medical Diagnostic Equipment**

The Ability Center is strongly supportive of the Department's efforts to apply specific requirements for accessible medical diagnostic equipment. While the final standards for MDE were released last year, there is no law yet that sets out scoping requirements for medical providers. Setting scoping requirements under 85.92(B) is needed for advocates to enforce this requirement.

During a survey promulgated throughout Ohio in 2021, The Ability Center repeatedly heard from constituents that they lacked the ability to receive preventative care because their physicians lacked accessible diagnostic medical equipment. One survey participant stated that she had not been weighed by her doctor in over a decade due to a lack of an accessible scale. Repeatedly, participants mentioned that OBGYN and dentist's offices, in particular, lacked accessible diagnostic medical equipment. A 2021 report from the National Council on Disability

also found that health care professionals often skipped parts of examinations due to inaccessible MDE.<sup>xliv</sup>

Beyond simply having MDE, physicians' offices also need to be trained to use MDE and to actually use it. Many medical staff are unfamiliar with the proper use of accessible MDE even when it is available.<sup>xlv</sup>

For comment on the specific scoping requirements, we adopt and incorporate the comments of the National Disability Rights Network here.<sup>xlvi</sup>

## **B. Childcare, Preschool, Elementary and Secondary, and Adult Education**

*Child Care, Preschool, Elementary and Secondary, and Adult Education Question 1: The Department wants to better understand potential impacts of the proposed rule on these recipients and requests comment on the application of the proposed rule to childcare providers and any potential barriers to compliance.*

The Ability Center is strongly supportive of the Department's efforts to update the regulations for childcare, preschool, elementary, secondary, and adult education.

Section 84.31, which provides that Section 504 applies to all recipients of federal funding – including public or private preschools; childcare centers; family childcare homes; and other entities that receive federal funds through a grant, loan, contract, or voucher – is especially important. While this does not change the law, many of these recipients claim that Section 504 does not apply to them. Mainstreamed childcare and education is key to disability rights because children are accepting of differences and learn to interact with playmates with disabilities just like those without disabilities. Updating this provision will help ensure that these educational settings are as inclusive as possible.

## **C. Conclusion**

The Ability Center thanks The Department for this opportunity to comment. Please feel free to reach out with any additional questions or to request any additional feedback.

Sincerely,

/s/ Katherine Hunt Thomas  
Katherine Hunt Thomas  
Director of Advocacy and  
Disability Rights Attorney

/s/ Jordan Slutsky  
Jordan Slutsky  
Disability Rights Intern

/s/ Sally Fish  
Sally Fish  
Disability Rights Advocate

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<sup>i</sup> Kim E. Nielsen, *A Disability History of the United States*, Beacon Press, p 166 (2012).

<sup>ii</sup> [Id. at 166-167.](#)

<sup>iii</sup> [Id. at 168-169.](#)

<sup>iv</sup> *Bragdon v. Abbott*, 524 U.S. 624(1998).

<sup>v</sup> Tara Lagu; Carol Haywood; Kimberly Reimold; Christene DeJong; Robin Walker Sterling; and Lisa Lezzoni, 'I Am Not The Doctor For You': Physicians' Attitudes About Coring For People with Disabilities, *Health Affairs*; Vol. 41, No.10, p1365-1530 (October 2022).

<sup>vi</sup> [Id.](#) at 1391.

<sup>vii</sup> [Id.](#)

<sup>viii</sup> [OF DIAGNOSES AND DISCRIMINATION: DISCRIMINATORY NONTREATMENT OF INFANTS WITH HIV INFECTION, 93 Colum. L. Rev. 1581, 1581](#)

<sup>ix</sup> National Council on Disability, *Organ Transplant Discrimination Against People with Disabilities: Part of the Bioethics and Disability Series*, 11 (September 25, 2019).

<sup>x</sup> [Id.](#) at 29.

<sup>xi</sup> [Id.](#) at 30.

<sup>xii</sup> [Id.](#) at 31.

<sup>xiii</sup> Betty W. Levin et al., *Treatment Choice for Infants in the Neonatal Intensive Care Unit at Risk for AIDS*, 265 *JAMA* 2976, 297680 (1991).

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<sup>xvii</sup> [Id.](#)

<sup>xviii</sup> [Id.](#)

<sup>xix</sup> National Council on Disability, *Organ Transplant Discrimination Against People with Disabilities: Part of the Bioethics and Disability Series*, 33 (September 25, 2019).

<sup>xx</sup> [Id.](#)

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<sup>xxiii</sup> Ari Ne'eman, Steven Kapp, Caroline Narby, *Organ Transplantation and People with I/DD: A review of Research, Policy, and Next Steps*, ASAN, Autistic Self Advocacy Network, Policy Brief, 5 (March 2013).

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<sup>xxvi</sup> *Bragdon v. Abbott*, 524 U.S. 624(1998).

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