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November 13, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Discrimination on the Basis of Disability in Health and Human Service Programs or Activities (RIN 0945–AA15)

Dear Secretary Becerra:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing in response to the Notice of Proposed Rulemaking on Discrimination on the Basis of Disability in Health and Human Service Programs (HHS) or Activities issued by the HHS Office for Civil Rights (OCR).

The proposed rule would add new provisions that clarify existing requirements under section 504 of the Rehabilitation Act of 1973, which prohibits recipients of financial assistance from the Department of discriminating on the basis of disability in their programs and activities. Specifically, the rule would update existing Section 504 regulations to ensure they are interpreted consistently in light of legislative, judicial, and regulatory developments over the last 50 years since the original Act; clarify and extend the section's requirements to several areas not previously explicitly addressed through regulation; and advance equitable access and bolster protections for people with disabilities. It primarily does this by proposing new non-discrimination standards for medical services, patient communications, and value assessment methodologies, as well as new accessibility standards for medical equipment and "new technologies" including web-based content and mobile phone applications. The rule also proposes new clarifications to existing integrated care setting requirements.

The AMA applauds the Administration's commitment to ensuring that qualified individuals are never subject to discrimination in medical treatment on the basis of disability. **The AMA believes firmly that discrimination has no place in the practice of medicine.** We established guidelines to prevent and address systemic racism, bias, and microaggressions in the practice of medicine and remain committed to fostering an environment in which all patients, including those with disabilities, feel informed and empowered to make decisions regarding their own care. Addressing accessibility for people with disabilities will narrow gaps in care and health and may improve care and health for all patients.

We strongly support many of the specific proposed changes in this rule. Many sections do a skilled job of balancing protections for individuals with disabilities while accounting for necessary clinical discretion and expertise of physicians, as well as the administrative burden of implementing these changes on practices, particularly those with fewer resources treating socially and economically disadvantaged populations. For example, the deeming approach to new medical device equipment

requirements requires practices to come into compliance while mitigating potentially significant up-front costs, as well as helping to avoid supply chain issues. We similarly appreciate proposed limited exceptions when meeting requirements would result in a fundamental alteration to the program or activity or result in undue financial or administrative burden, and for smaller organizations, while still expecting practices to take all steps necessary to ensure individuals with disabilities receive the same benefits and services to the maximum extent possible. We believe these types of considerations are thoughtful and demonstrate the delicate balance between ensuring equitable access for individuals with disabilities without imposing insurmountable burdens on practices.

We recognize that improving equitable access for individuals with disabilities will require intention and additional resources. If not implemented thoughtfully and with appropriate levels of support, implementation of these requirements will present a challenge, particularly for under-resourced practices serving disadvantaged patient communities. We have serious concerns with the proposed new technical accessibility standards for web-based content, social media content, and mobile phone applications in particular. While we strongly support making sure web-based technologies and phone applications are fully accessible to individuals with disabilities, we are concerned that the proposed approach of requiring technical standards will impose unnecessary and undue burden, discourage utilization of these promising technologies, and subject practices to possible litigation over features that are largely out of their control. **We believe strongly that an alternative strategy of promoting accessibility standards web-based content and phone applications through health information technology (health IT) certification while working alongside the health care community to design a high-impact principles-based approach to cover remaining web-based and social media content would be more impactful and mitigate these adverse consequences**.

Regarding enforcement, we urge OCR to work collaboratively with practices through corrective action plans to improve access for individuals with disabilities, which is the ultimate goal of this rulemaking. To that end, we implore OCR to provide practices with necessary supports to comply with the finalized requirements, including but not limited to federal grants, centralized auxiliary aids and support services, and identifying other sources of funding, such as requiring health insurers to reimburse for auxiliary supports or aids. **The AMA offers our full cooperation toward this end so that the groundbreaking protections of this rule can be executed without causing undue burden on practices, particularly those serving marginalized communities.**

We elaborate further on each of these concepts in the comments that follow.

I. Non-Discrimination Standards for Medical Services

The AMA agrees that no qualified individual with a disability should, on the basis of disability, be subject to discrimination in medical treatment or end-of-life care decisions based on bias or stereotypes about that disability, judgments that an individual would be a burden due to their disability, or belief that the person has a lesser value than a person without a disability. We agree that, with proper supports, individuals living with disabilities can not only survive but thrive. A physician's goal is to provide the highest possible quality of care and life to all patients and empower them in their own medical decision making, which leads to better health outcomes. For patients with disabilities, we recognize that this may require additional supports, accommodations, or communicating in a different way, and physicians remain committed to using all the tools at their disposal to empower all their patients to be their own decision makers and to live as full, healthy lives as possible.

To that end, **the AMA appreciates the careful consideration this section of the rule afforded to the importance of medical judgment and clinical discretion.** As experts with years of specialized clinical training, physicians are trained to account for a multitude of clinical, biological, social, and other risk factors in treatment decisions, and to help make patients fully aware of all possible options, including the risks associated with each, to jointly come to a decision about which course of treatment will yield the best possible outcome for that patient. This includes accounting for whatever additional supports or accommodations may be necessary to ensure the greatest possible outcome and quality of life for that individual**. A disability should never be used as a disqualifying factor for any medical good, benefit, or service.** At the same time, physicians are obligated to use their clinical expertise to consider all attributes of a patient, including but not limited to any physical or other limitations such as a disability, and to consider the role these factors may play in the likelihood of a particular treatment plan being effective and successful for that individual patient, as the rule acknowledges. For example, even with additional supports, patients with disabilities may face more challenges recovering from a major surgical operation with an expected long path to recovery. Or, as the rule outlined, physicians may be more inclined to recommend a patient staying on their current medication rather than switching to a new one where the side effects are less well known due to concerns about possible interactions with their disability, and/or other medications that the patient may be taking due to their disability. These types of potential complications, challenges, or considerations that patients with disabilities may face should always be openly discussed with the patient and/or caregiver in conversations about possible treatment options, as they would with any other patient.

We strongly support OCR's recognition of the importance of clinical discretion and encourage them to continue to recognize this in their enforcement of these provisions. To be abundantly clear, where there is a clear pattern of discriminatory behavior, we support enforcement within the full effect of the law. At the same time, when enforcing these provisions of the rule, we urge the Department to leave space for physicians to leverage their clinical expertise and professional judgment when making individualized recommendations to patients in consideration of their unique qualities and circumstances.

We appreciate the clarification that any individual who poses a significant risk to others will not be considered "qualified" and thus subject to the protections under this clause if reasonable modifications will not eliminate that risk provided that a determination is made based on an individualized assessment, rather than generalizations or stereotypes. Physicians are committed to providing equitable access to all their patients, but they also have a responsibility to ensure the health and safety of their staff and patients to the best of their ability, so we appreciate this clarification, particularly in the wake of growing violence against medical staff.[1]

We further appreciate CMS' clarification that individuals living with a substance or alcohol use disorder are considered protected individuals with disabilities if their impairment substantially limits one of their major life activities, as consistent with the American Disabilities Act, as well as clarifying that nondiscrimination provisions extend to the child welfare system. We have long advocated for protections for these two populations, which align with clinical evidence that alcohol and substance use disorders should be taken seriously as physical/mental disorders and those individuals afforded appropriate protections and supports under the law, and that parents, children, and other individuals within the child welfare system should not be discriminated against on the basis of disability, with overwhelming evidence of harm from separating children from their parents and that removal should generally be a last resort when the parents present an immediate danger to the child or can no longer appropriately care for

[1] Protecting physicians from violence requires all hands on deck | American Medical Association (ama-assn.org)

the child.[2] We agree that the focus should be on proactively identifying disabilities and making appropriate accommodations and identifying supports, rather than using disability as a basis for disqualification. Likewise, we appreciate the addition of timely clinical scenarios to be added to the list of physical/mental health impairments, including long-COVID, particularly as it impacts nearly one in five adult Americans who have had COVID[3] and disproportionately impacts communities of color.[4]

II. Clarification of Existing Requirements to Provide Services in the Most Integrated Care Setting

The AMA supports the proposed clarification specifying that current Section 504 requirements concerning delivering care in the most integrated setting also apply to the provision of community-based services such that provision of these services to persons with disabilities is mandatory when such services are appropriate, the individual does not oppose it, and placement in a community setting can be reasonably accommodated. The AMA recognizes the clinical value of community-based services and settings and that patients and their families often prefer community-based services, and we agree that individuals should not be excluded from equal participation in these activities due to their disability status. We also recognize that the level of integration can vary widely across states and organizations, and that there is evidence of unequal minoritized access to home and community-based alternatives, including long-term care services, underscoring that this issue involves other important racial and cultural inequities as well.[5]

At the same time, we appreciate OCR's clarification that those determinations may take into account the resources available to the entity and the needs of others receiving disability services from the entity. To this end, we would support finalization of this proposal and reiterate our ask for OCR to provide additional resources to help ensure health care organizations are able to offer the necessary auxiliary supports so that individuals with disabilities can fully participate in programming and activities to the same extent as other individuals while helping to ensure other programming remains at full capacity.

III. Patient Communications

The AMA agrees that effective communication to all individuals, including those with hearing, vision, and speech impairments, is critical to avoid communication failures and ensure better health care outcomes. For individuals with disabilities, we recognize this often requires the use of auxiliary aids and services such as qualified interpreters, information in Braille, large print, or computer screen-reading programs, which come with added costs. Accordingly, we urge OCR to provide practices, particularly those that are resource-challenged or those serving large disabled populations, with support to comply with finalized requirements, including but not limited to federal grants or centralized interpretive resources and/or auxiliary aides, as well as identifying other sources of funding, such as requiring health insurers to reimburse for auxiliary supports or aids. The AMA also appreciates and underscores the importance of the proposed exemption when complying with these provisions would result in a fundamental alteration in the program or activity or undue financial and administrative burden, while still expecting practices to take all steps necessary to ensure individuals with disabilities otherwise receive the same benefits and services to the maximum extent possible. We urge OCR to work with practices who

[2] https://www.americanbar.org/content/dam/aba/publications/litigation_committees/childrights/child-separation-memo/parent-child-separation-trauma-memo.pdf
[3] https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/20220622.htm
[4] https://www.census.gov/library/stories/2023/05/long-covid-19-symptoms-reported.html
[5] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.0126

may be found noncompliant and to provide additional resources and support to help bring them into compliance, rather than taking a punitive approach.

IV. Accessibility of Medical and Relevant Non-Medical Equipment

In the proposed rule, CMS proposed to add standards for new construction and alterations, which would apply both to new and previously existing facilities. The rule would also codify scoping requirements for medical diagnostic equipment (MDE) based on the Access Board's existing MDE standards. Among these would be specific standards concerning exam tables and weight scales, specifically that practices must have at least one of each that meets MDE standards within two years of the rule's publication. Practices must also properly maintain the equipment and ensure it is generally in operable working condition and have knowledgeable personnel to operate the equipment.

The AMA generally supports these proposed requirements and appreciates the Department's measured approach to scoping requirements, particularly the deeming approach to implementation, which allows organizations time to come into compliance as they update equipment over time, minimizing up-front expenses that could place practices in financial jeopardy, and avoiding supply chain issues. We similarly support approaching compliance based on a program in its entirety while affording organizations certain flexibilities in how equitable access is achieved, such as not mandating that every single facility or piece of equipment owned by a Section 504 covered organization must be compliant and not requiring excessive structural retrofitting of existing facilities if other methods can be similarly effective in achieving access, provided it does not come at great cost or inconvenience to the patient. We believe this approach ensures equitable access to MDE for individuals with disabilities while balancing practical concerns related to implementation and expense, thereby minimizing the potential for disrupting access to care for other patients. For similar reasons, we support the exclusion under consideration that would allow smaller entities to refer patients to other facilities within a reasonable distance if complying would require significant alternation to existing facilities. Lastly, we appreciate OCR's concerted efforts to align requirements under this section with existing Access Board MDE requirements and building accessibility codes, which helps to minimize confusion and redundancies, promote compliance, and minimize burden on practices.

We appreciate the Department's intention to ensure access to non-diagnostic equipment, and we support these efforts. However, we believe that the requirements already included in this NPRM will require a substantial effort on behalf of practices, so we would urge OCR not to finalize any such policies in this rule without input from interested parties, and to instead allow organizations time to adjust to the proposed policies before introducing additional requirements so as not to overwhelm and overburden practices and help ensure their success in complying with the existing proposed new requirements.

Lastly, we have concerns regarding the extension of responsibility for these provisions to facilities not directly controlled by the Section 504 covered organization. In addition to more clarification on this point, we reiterate our requests for a collaborative enforcement approach in which OCR works with organizations to bring them into compliance, as opposed to holding organizations responsible for decisions that are beyond their control, and to fully consider appropriate exceptions when complying with requirements would result in undue burden or cost.

V. Accessibility Standards for New Technologies

The AMA agrees that the rise of new technologies plays an increasingly important role in accessing health care services and activities. **We appreciate the need for the administration to specify how**

general Section 504 provisions would apply to these new technologies including kiosks, web-based content, mobile phone applications, as well as social media content.

We support the principles-based approach of including general language recognizing that section 504 prohibits recipient organizations from discriminating on the basis of disability in programs or activities provided through kiosks. We further strongly support the proposal that health care entities with kiosks may make their programs accessible by instituting procedures that would allow persons with disabilities who cannot use kiosks because of their inaccessible features to access the program without using kiosks provided such workarounds afford persons with disabilities the same access, convenience, and confidentiality that the kiosk system provides. For example, a clinic or a social services office may allow persons with disabilities to go directly to the personnel at the main desk to register for necessary services. We believe that this principles-based approach appropriately balances assuring section 504 protections are applied to services offered through kiosks, while not overburdening practices when there are reasonable alternative solutions that offer a comparable experience.

While the AMA strongly supports requiring that web content and mobile applications used to offer programs or activities to members of the public be made accessible to individuals with disabilities, evidence suggests that implementing WCAG 2.1 AA standards is likely to be a substantial cost burden on health care entities across the country. The costs for these types of updates could range from $7,000 to $23,500 plus an additional $800 to $1,500 each month.[6] That figure is simply not sustainable, particularly for under-resourced practices such as small, rural, and safety net institutions and those serving large disabled populations.

OCR states in the rule that it chose WCAG version 2.1 because organizations "are likely already familiar with WCAG 2.1 or will be able to become familiar quickly" citing its availability since 2018. However, its own examples do not support this. The rule states that only four states "either use or ***strive*** to use a WCAG 2.1 standard or greater for at least ***some*** of their state web content." There are several issues with this. First, this rule would apply to any recipient of financial assistance from the Department, including small organizations, which are very different than state-level entities. Furthermore, this count includes states that are "striv[ing]" to meet that standard and includes those where the WCAG 2.1 standards apply to only "some" of their web content, with no minimum specified. The rule goes on to explain that "of more than 100 top hospitals across the U.S.… only 4.9 percent are compliant with WCAG 2.1." While the AMA supports efforts to move the industry toward adoption of accessibility standards, clearly the industry is far from being ready to meet the WCAG 2.1 standard. Two to three years is simply not enough time, especially considering that practices will be reliant on third-party web developers. Furthermore, if every Section 504 covered health care entity in the country is attempting to make these updates during the same two-to-three-year window, this will result in substantial backlogs and delays making universal compliance within that timeframe even less feasible. The Department seemed to recognize similar practical resource limitations in the scoping section of this rule by adopting a gradual deemed approach to implementation, yet fails to apply the same considerations for the web-based standards, which we feel present a greater burden.

Critically, successful implementation of this section does not rest squarely on practices, but rather on a third-party application or web content developer. Given that patient portals, scheduling applications, and telehealth portals are often developed and administrated by certified health IT developers who are also HIPAA business associates, we believe that building access requirements into existing certification standards would be a more straight-forward and successful way to successfully drive accessible content

[6] https://www.skynettechnologies.com/blog/cost-to-make-website-ada-compliant

while drastically mitigating cost and burden. Specifically, **OCR should work with the Office of the National Coordinator for Health IT (ONC) to include accessibility as a health IT certification criterion.** Ensuring that the certified health IT community has information on the most-widely used data standards will help promote consistency and provide greater access for individuals with disabilities while minimizing burden on medical practices.

Any remaining web-based content should be addressed through a principles-based approach, consistent with the approach for kiosks. We disagree strongly that such an approach would be too vague, subjective, or insufficient as the rule claims. To the contrary, if OCR works closely with the AMA and other interested parties in developing these principles, it could develop a set of highly concrete, targeted priorities that would focus on the most effective ways to advance accessibility while drastically mitigating the burden of implementation, not to mention greatly reduce the risk of frivolous lawsuits over small technicalities. Just as OCR provides examples of specific real-world applications for Section 504 in this proposed rulemaking, it could just as easily provide examples or a template for what would demonstrate compliance with principles-based accessibility requirements to help ensure clarity of expectations and bolster compliance.

Furthermore, OCR does not lay out a clear compliance strategy for enforcing these proposed new technical requirements, but rather seeks comment on general enforcement approaches, which it says it intends to address in the final rule. The Department provides several possible approaches ranging from a percentage-based approach to one based on "organizational maturity." Notably, OCR indicates in the rule that "a more nuanced definition of compliance might be appropriate because some instances of nonconformance with WCAG success criteria may not meaningfully impede access to the programs or activities offered through a public entity's web content or mobile app but could put practices at risk of litigation and bog down the HHS complaints system with small infractions." We could not agree more, but believe this approach to enforcement is in direct conflict with the proposed technical standards approach. We do not understand why OCR would implement highly technical, burdensome standards in the first place if it acknowledges that small infractions could "bog down the HHS complaints system with small infractions" and that enforcing each provision would be problematic. While OCR says it wants to implement standards to provide ease of understanding, we believe the highly technical standards coupled with this piecemeal enforcement approach introduces more complexity and confusion. Notably, HIPAA already has a well-established implementation and enforcement procedure. An accompanying principles-based standard to cover remaining web-based criteria that is focused on a select set of high-impact criteria that are all equally enforced would more meaningfully improve access for individuals with disabilities, with less confusion and burden than enforcing 76 separate metrics in piecemeal fashion.

Importantly, the combined health IT certification and principles-based alternative would not preclude overlap of effective WCAG requirements. Rather, it would allow a joint OCR-ONC effort to customize the content to focus on the most high-impact criteria from multiple access-based web content standards including WCAG 2.0, 2.1, and 2.2, Access Board section 508 Standards, and other relevant sources. OCR seeks comment in the rule on whether it should adopt additional Access Board standards not included in WCAG 2.1. A principles-based strategy, along with close OCR-ONC coordination around health IT certification, would provide an opportunity for an array of the most highly effective tactics, rather than boxing developers into one imperfect standard.

In addition to the general proposed exceptions for smaller organizations or excessive burden or cost, OCR proposes several exceptions specific to web content including archived web content, preexisting electronic documents, web content posted by third parties on an organization's website (e.g., message forums), third-party web content linked from an organization's website, and secure electronic documents

specific to the individual (such as billing statements). Similarly, the rule includes a proposed exception for social media content posted before the rule's effective date. These exceptions would be subject to certain limitations, including that organizations are still generally expected to still make these documents accessible to individuals with disabilities within a timely manner upon request and that individuals with disabilities cannot be prevented from having access to all of the organization's programs and activities as a result of these exclusions. As one example, if the website links to a third-party website for payment, then that third-party website should comply with web accessibility requirements. The AMA strongly supports all proposed exceptions on the basis that they would help to mitigate the substantial burden on practices that would arise should these policies be finalized. The AMA strongly urges OCR to reconsider similar exceptions for external mobile apps. While some of the exceptions may not be as applicable, certain applications do apply, including archived content for example, and there is no reason to universally exclude mobile applications from these important burden-mitigating exceptions or to isolate them from web-based content when both are often utilized for similar, if not the same, purposes.

We strongly urge OCR to reconsider allowing the creation of a ''conforming alternate version,'' i.e., a separate web page that is accessible, up-to-date, and contains the same information and functionality as the inaccessible web page, to provide individuals with disabilities access to the same information and functionalities provided to individuals without disabilities, which is permitted under WCAG 2.1. We fundamentally disagree that this would be inconsistent with section 504's core principles of inclusion and integration and may result in unequal access to information and functionality. The fact that these standards require the same up-to-date information and functionalities inherently makes it so that individuals who are disabled do not have an inferior experience. Moreover, not trying to house all information in different formats on a single webpage is likely to improve the functionality of the site for both the abled and disabled, which is precisely why it was built into WCAG 2.1 requirements. We urge OCR to reverse this proposal and allow a conforming alternative version of a webpage to satisfy Section 504 web-based accessibility requirements regardless of which policy it finalizes.

Similarly, we urge OCR to reconsider allowing 24/7 staffed telephone lines to satisfy accessibility requirements for web- and application-based content. While we share concerns over potentially long wait times, we would urge the Department to instead impose maximum wait time requirements, which we believe would address its chief concern with phone lines as an alternative while allowing practices some flexibility in determining how best to offer individuals with disabilities equal access to services without undue cost or burden. Allowing these types of reasonable alternative accommodations will also likely decrease the number of practices seeking exceptions under the burden and cost exception, which will ultimately result in more patients having equitable access, which is the goal.

At the end of the day, we are concerned that if these new highly stringent technical requirements are finalized as proposed, organizations will be hesitant to leverage these technologies to promote access to services or activities altogether, for fear of opening themselves to possible litigation, potentially losing out on these valuable tools to help spread the word about vaccines, cancer screenings, and countless other important service offerings. The AMA strongly supports expanding accessible access to services for those with disabilities including through web-based content and phone applications, but we do not believe that this has to come at the expense of potentially limiting the benefits of promising new technologies. Unlike the generally balanced proposals in other sections of this rule, these stringent standards for web-based content and other new technologies stand out as being overly prescriptive and shutting the door on reasonable alternative solutions for no clear discernable reason. **We believe strongly that our alternative to incorporate access requirements into health IT certification, coupled with a principles-based approach for remaining web and social media content, would minimize cost and**

burden while engaging multiple sectors of the market towards the same goal for more transformational change.

Should OCR not accept our alternative recommendation and instead move forward with its proposal to implement WCAG technical requirements, we recommend **at a minimum** OCR make the following adjustments to mitigate the burden on practices and health care entities:

- Finalize WCAG 2.0 or a subpart of 2.0 requirements in lieu of 2.1 to allow health care organizations and third-party developers to focus on the most impactful items in the near term while building towards 2.1 in the future since 2.1 builds on 2.0.
- Finalize Level A in lieu of Level AA to allow organizations to focus on meeting baseline requirements first while building towards Level AA in the future.
- Implement a phased or deeming implementation approach to minimize widespread disruptions from the industry adapting to new standards within the same two-to-three-year period, or at a minimum, extend the implementation timeframe.
- Finalize all proposed exceptions, extend these exceptions to phone applications, and allow requirements to be satisfied via a separate accessible webpage and/or 24/7 staffed phone line.

Regardless of the approach taken, we further request, as consistent with other requirements in this rule, that the Department take a collaborative approach to enforcing these provisions, working with organizations to identify any deficiencies and develop corrective action plans. With web-based requirements and applications, additional supports including but not limited to centralized technology supports or federal grants to help organizations comply with this rule will be even more critical, particularly for practices with fewer resources or serving high proportions of disabled populations.

VI. Value-based Assessment and Distribution Methods

The AMA supports the proposal to apply Section 504 protections to value-based assessment and distribution methods including scenarios of scarce resource allocation. We agree that all health care organizations covered by this statute should be prohibited from basing decisions using criteria that discriminate against any individual on the basis of disability and must provide reasonable modifications in the administration of assessment tools to ensure that the tools measure accurately what they are intended to measure in people with disabilities. The AMA has taken a clear stand against any algorithms that may result in disparate care for any group of individuals, including those with disabilities. Appropriate regulation and clinical implementation of clinical algorithms have been a top priority for the AMA for several years. As part of that work, the AMA has a strong interest in ensuring that use of algorithmic-based tools do not result in discriminatory outcomes that harm patients. Accordingly, we share OCR's concern that certain algorithms may introduce bias into outputs or otherwise inappropriately incorporate other inputs that may result in discriminatory harm to patients. The AMA supports OCR's goal of reducing discriminatory harms resulting from clinical algorithms and supports ongoing examination of how health care algorithms and decision tools informed by algorithms may contribute to inequities in access to care, quality of care, and health outcomes for underserved populations. **We would like to point out the importance of the liability for these resultant harms resting with the parties that design and control the discriminatory algorithms, as opposed to the downstream individual physicians and practices who utilize them.**

VII. Exceptions

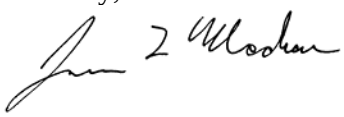
The rule proposes two general, limited exceptions that would apply to several requirements of this proposed rule including one for smaller organizations (those of fewer than 15 employees), as well as when compliance actions would result in a fundamental alteration in the program or activity or undue financial and administrative burdens, provided that organizations still take any other steps necessary to ensure that individuals with disabilities receive the same benefits and services to the maximum extent possible. In addition, the burden of proof would rest solely with the Section 504 covered organization and must be requested by the head of the organization and accompanied by a written statement of the reasons for reaching that conclusion. **The AMA strongly supports the protective requirements in this rule. We also strongly support these proposed exclusions because they would help to avoid circumstances in which complying with the requirements could present an insurmountable burden to practices and negatively impact a practice's resources for delivering care to all patients, including the disabled.** We urge the Department to finalize both these policies as proposed, with the exception that we would ask them to consider broadening the exception for small organizations to practices of fifteen or fewer clinicians, as consistent with the definition of small practices in the Medicare Access and CHIP Reauthorization Act.

In Conclusion

The AMA appreciates this opportunity to provide comments on this critically important topic. We recognize the historic importance of this rule and are deeply committed to advancing the rights and protections of those living with disabilities. We support many of proposals in this rule, which we find to be thoughtful and balance the practical complexities of implementation. However, we have strong concerns regarding the proposed technical standards for web-based content and phone applications and we strongly urge the Department to replace this proposed approach with a dual approach focused on health IT certification and an accompanying principles-based approach developed in close collaboration with interested parties. We urge OCR to take a collaborative approach to enforcement to work towards maximum compliance with these new protections and to provide organizations with necessary resources and supports to facilitate compliance while continuing to deliver high-quality care to all their patients, including the disabled.

The AMA looks forward to working with the Department to ensure implementation of these provisions is successful at achieving its goal of expanding access to health care services and activities for those with disabilities while being as minimally burdensome as possible. Please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409 to discuss the content of this letter.

Sincerely,



James L. Madara, MD