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A. Section 504 Regulations

As discussed, in Section 2, with the passage of the Rehabilitation Act of 1973, Congress established a comprehensive federal plan aimed to end discrimination based on handicap in any program or activity receiving federal financial assistance. On May 4, 1977, the Department of Health, Education and Welfare finally issued regulations implementing Section 504.¹ In 1979, Congress divided the Department of Health, Education and Welfare (HEW) into two new agencies, the Department of Education and the Department of Health and Human Services (HHS).² When the U.S. Department of Health and Human Services was created on October 1, 1980, the Section 504 Regulations were automatically transferred to HHS for adoption.³ Other federal agencies have also published regulations implementing Section 504 and most have modeled their regulations after the original HEW implementing regulations. The HHS Section 504 regulations are located in the Code of Federal Regulations at 45 C.F.R. §§ 84.1 – 84.10; §84.52 & 84.61.⁴

Congress amended the Rehabilitation Act in 1978, adding a new Section 505(a)(2), incorporating the remedies of Title VI of the Civil Rights Act of 1964,⁵ and Section 505(b)

¹ 45 C.F.R. § 84 (1987).

² See Department of Education Organization Act, Pub. L. No. 96 – 88, 93 Stat 668 (1979)

³ 20 U.S.C. § 3508 (1982).

⁴ Title 45, Public Welfare; Subtitle A, Department of Health and Human Services; Subchapter A, General Administration; Part 84, Nondiscrimination on the Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance, 45 C.F.R. §§ 84.1 et seq.

⁵ [Pub. L. No. 88-352](#), [78 Stat. 241](#) (1964) (codified as amended at 42 U.S.C. §§2000a–2000h-6).

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authorizing the court to award attorneys' fees for any prevailing party. In the legislative history of the 1978 amendments Congress noted that persons with disabilities were one of the very few minority groups in this country who have not been permitted by Congress to seek attorney's fees.⁶ The committee further believed that the rights extended to "handicapped individuals under the [Rehabilitation Act] – that is, Federal Government employment, physical accessibility in public buildings, employment under Federal contracts, and nondiscrimination under Federal Grants – are, and will remain in need of constant vigilance by handicapped individuals to assure compliance and the availability of attorney's fees should assist in vindicating private rights of actions..."⁷

The purpose of the Section 504 regulations is to effectuate Section 504 of the Rehabilitation Act of 1973, which is designed to eliminate discrimination on the basis of handicap in any program or activity receiving Federal financial assistance.⁸ "Federal financial assistance" means any grant, loan, contract (other than a procurement contract or contract of insurance or guarantee) or any arrangement by which the Department of Health and Human Services provides or otherwise makes available assistance in the form of funds, services of federal personnel or real and personal property.⁹ Receipt of payments of financial reimbursement under Medicare and Medicaid have been deemed "federal financial assistance" for purposes of the application of Section 504.¹⁰ Therefore, any healthcare system, hospital, medical group, dental group,

⁶ H.R. Rep. No. 1149, 95th Cong., 2d Sess. 21, reprinted in 1978 U.S. Code Cong. & Ad. News 7312, 7332

⁷ S. Rep. No. 890, 95th Cong., 2d Sess. 19 (1978).

⁸ 45 C.F.R. §84.1

⁹ Id. at § 84.3

¹⁰ See [United States v. Baylor Univ. Medical Ctr.](#), [736 F.2d 1039, 1042](#) (5th Cir. 1984)(We ground our determination that the receipt of Medicare and Medicaid payments triggers *Section 504* coverage on three congruent sources: the legislative history of that group of statutes prohibiting discrimination in federally funded programs--Title VI,

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behavioral health provider, individual physicians, dentists or any other provider of health related services that participates in Medicare and Medicaid are subject to the requirements of Section 504.

Section 504 was explicitly patterned after the seminal discrimination provisions of Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race or national origin in federally funded programs and mirrors the provisions of Title IX of the Education Amendments of 1972, which prohibits discrimination on the basis of sex in federally funded educational programs.¹¹ One specific area of discrimination that concerned Congress at the time Title VI was passed, in 1964, was discrimination by hospitals and other medical facilities in the provision of healthcare services. It was intended that Title VI counteract existing racial

Title IX and the Rehabilitation Act, judicial interpretation of these, and regulations adopted pursuant to them. Our examination of these sources indicates that this court could not excuse from the coverage of *Section 504* and its counterparts hospitals that participate in Medicare and Medicaid without frustrating Congress' clear and consistent purpose to protect handicapped persons and members of minority groups from discrimination in programs receiving federal assistance). *See also NAACP v. Wilmington Medical Center, Inc.*, [599 F.2d 1247, 1248](#) n. 4 (3d Cir.1979), *aff'd in relevant part*, [453 F.Supp. 280](#), later proceeding, [453 F.Supp. 330](#) (D.Del.1978)(affirming district court determination that hospital's receipt of Medicare, Medicaid and unspecified "other" assistance triggered *Section 504* and Title VI); *United States v. University Hospital of SUNY at Stony Brook*, [575 F.Supp. 607](#) (EDNY 1983), *aff'd on other grounds*, [729 F.2d 144](#) (2d Cir.1984)(legislative history reveals Medicare and Medicaid are "federal financial assistance for purposes of § 504"); *United States v. Cabrini Medical Center*, [497 F.Supp. 95, 96](#) n. 1 (SDNY 1980), *rev'd on other grounds*, [639 F.2d 908](#) (2d Cir.1981)(same); *Cook v. Ochsner Foundation Hospital*, Civ. No. 70-1969 (E.D.La. February 12, 1979)(same); *Bob Jones University v. Johnson*, [396 F.Supp. 597, 603](#) n. 21 (D.S.C.1974), *aff'd without opinion*, [529 F.2d 514](#) (4th Cir.1975)(district court finds Medicare and Medicaid to be federal financial assistance for Title VI purposes); *see also Bernard B. v. Blue Cross and Blue Shield*, [528 F.Supp. 125, 132](#) (SDNY 1981), *aff'd without opinion*, [679 F.2d 7](#) (2d Cir.1982)(district court assumes that Medicare constitutes "federal financial assistance" in holding that if Medicare linked to discriminatory program plaintiffs may state a *Section 504* case); *Flora v. Moore*, [461 F.Supp. 1104, 1115](#) (N.D.Miss.1978)(stating in dicta that Medicare and Medicaid invoke Title VI protection).

¹¹ *See* S.Rep. No. 93-1297, 93d Cong., 2d Sess., *reprinted at* [1974] U.S.Code Cong. & Ad.News 6373, 6390 ("*Section 504* was patterned after, and is almost identical to, the anti-discrimination language of *section 601* of the Civil Rights Act of 1964").

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discrimination for medical care of public assistance recipients in hospitals, nursing homes and clinics in all parts of the country.¹²

Section 504 has a number of important defined terms. As used in Section 504, “handicapped person” means any person who has (i) a physical or mental impairment which substantially limits one or more major life activities, (ii) has a record of such impairment, or (iii) is regarded as having such an impairment.¹³ “Physical or mental impairment” means any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.¹⁴ “Major life activities” means the functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.¹⁵ “Has a record of such an impairment” means has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.¹⁶ “Is regarded as having an impairment” means has a physical or mental impairment that does not substantially limit major life activities, but rather, is treated by a recipient of Federal financial assistance as constituting such a limitation; has a physical or mental impairment that

¹² 110 Cong. Rec. 1661 (1964).

¹³ 45 C.F.R. § 84.3(j)

¹⁴ *Id.* at § 84.3(j)(2)(i).

¹⁵ *Id.* at § 84.3(j)(2)(ii).

¹⁶ *Id.* at § 84.3(j)(2)(iii).

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substantially limits a major life activities only as a result of the attitudes of others towards such an impairment; or is treated by a recipient of Federal financial assistance as having such an impairment.¹⁷

Persons living with paralysis and mobility disabilities are considered “handicapped persons” for purposes of Section 504 because of their physical impairment affecting their neurological, musculoskeletal and/or cardiovascular systems which, depending upon the specific cause of their paralysis or mobility disability (*e.g.*, spinal cord injury, cerebral palsy, multiple sclerosis, Guillain-Barré syndrome, ALS, *etc.*) limits their ability to perform certain manual tasks, walking, and perhaps breathing. “Disability” by itself does not automatically entitle the person with paralysis or mobility disabilities with protections under Section 504. They also must be “qualified handicapped persons.” Meaning, with respect to the receipt of medical services, they must meet essential eligibility requirements for the receipt of such services.¹⁸ To establish that a person is “otherwise qualified,” a person must show that he can satisfy the essential eligibility requirements of the services for which he seeks.¹⁹ Thus, for example, a burn treatment center need not provide other types of medical treatment to handicapped persons unless it provides

¹⁷ *Id.* at § 84.3(j)(2)(iv).

¹⁸ *Id.* at § 84.3(l)(4). To establish a prima facie case under Section 504 of the Rehabilitation Act, plaintiffs must establish that: (1) they are individuals with a disability; (2) they were otherwise qualified to receive the benefits of a program; (3) they were denied the benefits of the program solely by reason of their disability; and (4) the program receives federal financial assistance. *Bax v. Doctors Med. Ctr. of Modesto, Inc.*, 393 F. Supp. 3d 1000, 1012, 2019 BL 246088, 9 (E.D. Cal. 2019); *Duvall v. County of Kitsap*, 260 F.3d 1124 , 1135 (9th Cir. 2001). A claim under the ACA is enforced through Section 504 of the Rehabilitation Act and is subject to the same standards. 42 U.S.C. § 18116(a) .

¹⁹ See *Wagner v. Fair Acres Geriatric Ctr.*, 49 F.3d 1002, 1009 (3d Cir. 1995) citing *Southeastern Community College v. Davis*, 442 U.S. 397, 99 S.Ct. 2361, 60 L.Ed.2d 980 (1979), the Supreme Court held that an “otherwise qualified” handicapped individual is one who can meet all of a program’s requirements in spite of his handicap. *Id.* at 406, 99 S.Ct. at 2368.

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such medical services to non-handicapped persons. It could not, however, refuse to treat the burns of a deaf person because of his or her deafness.²⁰

The Section 504 Regulations are strikingly sparse in detail as it relates to nondiscriminatory provision of healthcare services for persons with disabilities. Recall that the Section 504 provisions in the Rehabilitation Act 1973 were almost an afterthought. That was reflected in the lack of comprehensive rulemaking by the Secretary of Health Education and Welfare when the Section 504 regulations were drafted. Here are the regulations nutshell:

In providing healthcare services, a recipient of federal financial assistance, may not on the basis of disability deny a qualified person with a disability those services; afford such person an opportunity to receive services or benefits that is not equal to that offered nondisabled persons; provide such persons with benefits of services that are not as effective as the benefits of services provided to others; provide benefits or services in a manner that limits or has the effect of limiting the participation of such persons; or provide different or separate benefits or services to persons with disabilities except when necessary to provide qualified persons with disabilities with benefits and services that are as effective as those provided to others.²¹

There are additional subsections of the Section 504 Regulations that specifically provide requirements for the provision of communication assistance during emergency treatment of persons who are Deaf or hard of hearing.²² Recipients with 15 or more employees are required to adopt Section 504 grievance procedures and designate an employee to coordinate their compliance.²³ Recipients with 15 or more employees must take initial and continuing steps to

²⁰ 45 C.F.R. § 84.52 (c) & (d); pt. 84, app. A, subpt. F, §36; *see also id.* at §37 (“The provision does not mean that all hospitals and outpatient facilities must treat drug addiction and alcoholism. It simply means, for example, that a cancer clinic must not refuse to treat cancer patients simply because they are also alcoholics.”).

²¹ 45 C.F.R. §84.52(a)(1)–(5)

²² *See Id.* At § 85.52 (c) & (d)

²³ *Id.* at § 84.7

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notify participants, beneficiaries, applicants, and employees that they do not discriminate on the basis of disability. Notification may be made by posting a notice, publicizing in newspapers and magazines, etc.²⁴ The Section 504 regulations contain modest physical accessibility standards that do not require recipients to completely refit existing buildings, but mainly ensure that programs are accessible to persons with disabilities.²⁵ In 1984, HHS added an additional provision to the regulations setting forth mandatory and recommended procedures for recipients to follow regarding life-sustaining medical and nutritional care for infants who are disabled.²⁶

That is the sum and substance of the regulations that Congress initially enacted to stop discrimination against persons with disabilities in their receipt of healthcare services. While the Section 504 Regulations are striking in their paucity of detail, the general nondiscrimination mandate is written broad enough to allow persons with disabilities and their advocates to nevertheless take action to enforce their rights under Section 504 to address accessibility barriers existing today. Gratefully, the regulations implementing Title II and Title III of the Americans with Disabilities Act provide greater specificity to healthcare providers of their obligations to provide Accessible Healthcare, but as discussed below, not quite to the level of detail required from the perspective of persons with disabilities to allow them to simply point to the regulations when healthcare providers discriminate.

Finally, the Rehabilitation Act Amendments of 1992, among other things, substituted “disability” for “handicap” in the statute.²⁷

²⁴ *Id.* at § 84.8

²⁵ *Id.* at § 84.21 – 84.23

²⁶ *Id.* at §84.55

²⁷ Pub. L. 102-569, Sec. 102(p)(32).

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B. Regulations Addressing Accessible Healthcare under Title II and Title III of the Americans with Disabilities Act

In enacting the ADA, Congress found that individuals with disabilities continually encounter discrimination in access to public services, including both outright intentional exclusion and the failure to make modifications to existing practices.²⁸ The ADA was more than a mere extension of Section 504. Congressional records explicitly state that “the ADA is a final proclamation that the disabled will never again be excluded, never again treated by law as second-class citizens.”²⁹ Under the ADA, “we are simply saying that no longer can we tolerate the exclusion of the disabled because of ignorance, fear, or intolerance.”³⁰ In enacting Title II of the ADA, applicable to public entities (*i.e.*, facilities and services owned and operated by states, cities, counties and municipalities) Congress intended to ensure that all government services be provided effectively--with necessary accommodations and aides--in integrated settings and adopted as the ADA’s statutory purpose, the provision of a clear mandate to end all forms of segregation and discrimination, and provided clear standards for doing so.³¹ Upon signing the ADA into law, then-President George H.W. Bush stated that the ADA “promises to open up all aspects of American life to individuals with disabilities.... [e]xisting laws and regulations under the Rehabilitation Act of 1973 have been effective with respect to the Federal Government.... *However, they have left broad areas of American life untouched or inadequately addressed.*”³² In

²⁸ 42 U.S.C. § 12101(a)(3), (a)(5)

²⁹ 136 Cong. Rec. S9684 (daily ed. July 13, 1990) (statement of Sen. McCain).

³⁰ *Id.* (statement of Sen. Hatch).

³¹ See 42 U.S.C.A. §§ 12101(b)(1) & (2).

³² Statement by President George Bush upon signing S. 933, 26 WEEKLY COMP. PRES. DOC. 1165 (July 30, 1990) (emphasis added).

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addition, “Congress determined while creating the ADA, ... that Section 504 simply was not working as a means of eradicating discrimination and segregation in this country.”³³ Moreover, “[t]he Executive branch apparently agreed that the ADA was not simply a reenactment of previous legislation when it presented testimony on Capitol Hill in support of the ADA.”³⁴ At a 1989 Senate hearing, the then-United States Attorney General, Dick Thornburgh, stressed that ‘fifteen years have gone by since the Rehabilitation Act took effect, [n]evertheless, persons with disabilities are still too often shut out of the . . . social mainstream of American life.’³⁵ “Congress recognized that the Rehabilitation Act had not fulfilled the ‘compelling need . . . for the integration of persons with disabilities into . . . American life.’”³⁶ Congress, thus, “enacted the ADA ‘to continue to break down barriers to the integrated participation of people with disabilities in all aspects of community life.’”³⁷ While the Rehabilitation Act had a profoundly positive effect on the programs and activities they govern, “. . . the existing statutes do not go far enough toward establishing a broad legal condemnation of the discrimination confronting people with disabilities.”³⁸

³³ Timothy M. Cook, *The Americans With Disabilities Act: The Move To Integration*, 64 TEMP. L. REV. 393, 416 (1991) (quoting *District of Columbia Appropriations Bills, Hearings Before the Comm. on Appropriations*, 67th Cong. 96 (1923)).

³⁴ *Id.*

³⁵ *Id.* (quoting *Americans with Disabilities Act: Hearing Before the Subcomm. on the Handicapped, of the Senate Comm. on Labor and Human Resources*, 101st Cong. 195 (1989) (statement of former Attorney General Dick Thornburgh)).

³⁶ Brief of the United States as Amicus Curiae at 6, *Helen L. v. DiDario*, 46 F.3d 325 (3d Cir. 1995) (No. 94-1243) (quoting S. REP. NO. 101-116, at 20 (1989)S. REP. NO. 101-116, at 20 (1989)).

³⁷ *Id.* (quoting H.R. REP. NO. 101-485, pt. 3, at 49-50 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 472-73).

³⁸ 134 CONG. REC. S5107 (daily ed. April 28, 1988) (statement of Sen. Weicker).

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Title II Regulations Applicable to Public Entities

Title II of the ADA prohibits discrimination and segregation by all units of state and local government (*i.e.*, facilities and services owned and operated by states, cities, counties and municipalities).³⁹ In addition to its applicability to the government and its role in providing for transportation, education, housing, and other public services, it also applies to the delivery of healthcare, dental care, vision care, behavioral healthcare and any other health-related services provided by a unit of state and local government.⁴⁰ Units of state and local government are large providers of healthcare and healthcare related services. A survey conducted In 2018 by the *Kaiser Family Foundation*, reported there were 965 state or local government owned community hospitals in the United States, with Texas leading the way with 103, followed by California with 64.⁴¹ Delaware, District of Columbia, Maryland, New Hampshire, New Jersey Rhode Island and Vermont all reporting zero state or local government owned community hospitals.⁴²

The purpose of the Title II regulation, promulgated by the United States Attorney General, is to implement Title II of the Americans with Disabilities Act of 1990, prohibiting discrimination on the basis of disability by public entities.⁴³ The regulation became effective on January 26,

³⁹ The ADA is comprised of five titles: Employment (Title I); Public Services (Title II); Public Accommodations and Services Operated by Private Entities (Title III); Telecommunications (Title IV); and Miscellaneous Provisions (Title V).

⁴⁰ 28 C.F.R. § 35.102.

⁴¹ Kaiser Family Foundation, Hospitals by Ownership Type 2018. Available at <https://www.kff.org/other/state-indicator/hospitals-by-ownership/?dataView=1¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>; Defining community hospitals: All nonfederal, short-term general, and specialty hospitals whose facilities and services are available to the public. Source, 1999 - 2018 AHA Annual Survey, Copyright 2019 by Health Forum, LLC, an affiliate of the American Hospital Association. Special data request, 2019. Available at <http://www.ahaonlinestore.com>.

⁴² *Id.*

⁴³ 28 C.F.R. § 35.101.

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1992.⁴⁴ Within one year from the effective date of the regulation, public entities were directed to conduct a self-evaluation of their current services, policies and procedures and the effects thereof to determine what does not and what may not comply with the regulation's requirements. They were then required to develop a "transition plan" to "achieve program accessibility" by "setting forth the steps necessary to complete such changes."⁴⁵ The regulation recognizes that "in the case of older facilities, for which structural change is likely to be more difficult, a public entity may comply with Title II by adopting a variety of less costly measures, including relocating services to alternative, accessible sites and assigning aides to assist persons with disabilities in accessing services." *Tennessee v. Lane*, 541 U.S. 509, 532, 124 S.Ct. 1978, 158 L.Ed.2d 820 (2004). Accordingly, the Title II regulation differentiates between structures built before the effective date of the ADA and those built or altered after. Existing facilities constructed prior to January 26, 1992, are subject to 28 C.F.R. § 35.150, which requires only "program access."⁴⁶ "Program access" does not require that each and every facility is equally accessible to disabled persons.⁴⁷ Rather, it simply requires a public entity to "operate each service, program, and activity so that the service, program, or activity, when *viewed in its entirety*, is readily accessible to and usable by individuals with disabilities."⁴⁸ For example, a county that operates a medical campus and has a hospital and many clinics on that campus is not required to ensure the persons with paralysis or mobility disabilities can enter into and be treated in every

⁴⁴ §§ 108, 205, Pub. L. No. 101-336

⁴⁵ 28 C.F.R. § 35.150(d)(1)

⁴⁶ 28 C.F.R. § 35.150.

⁴⁷ *Id.* at §35.150(a)(1).

⁴⁸ 28 C.F.R. § 35.150(a) (emphasis added).

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building, but are required to ensure they receive the same level of care and treatment options as are afforded to persons who are not disabled in a clinically appropriate facility on their campus. Title II's emphasis on "program accessibility" rather than "facilities accessibility" was intended to ensure broad access to public services, while, at the same time, providing public entities with the flexibility to choose how best to make access available.

However, if a county is today constructing a new medical campus, physical accessibility to each of its buildings on the campus is required as "new construction and alterations" commenced after January 26, 1992, are subject to more exacting requirements. Specifically, "[e]ach facility or part of a facility constructed by, on behalf of, or for the use of a public entity shall be designed and constructed in such manner that the facility or part of the facility is *readily accessible* to and usable by individuals with disabilities, ..."49 To be "readily accessible," the facility "must be constructed in conformance with the Americans with Disabilities Act Accessibility Guidelines for Buildings and Facilities (ADAAG),⁵⁰ or with the Uniform Federal Accessibility Standards (UFAS)"⁵¹ The ADAAG is a comprehensive set of structural guidelines that articulates detailed design requirements to accommodate persons with disabilities. UFAS substantially mirrors ADAAG and sets forth uniform standards for the design, construction and alteration of federally owned and federally funded buildings so that persons with physical disabilities will have ready access to and use of them in accordance with the Architectural Barriers Act.⁵² In practice, in many instances it is far more cost-effective to plan for and incorporate

⁴⁹ [28 C.F.R. § 35.151\(a\)\(1\)](#) (emphasis added).

⁵⁰ [28 C.F.R. Pt. 36, App. A,](#)

⁵¹ 41 C.F.R. Pt. 101-19.6, App. A.

⁵² 42 U.S.C. §§ 4151-4157.

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accessibility features in the initial design and build than to have to do that after the fact.

The 965 state or local government owned community hospitals, and other state or local government owned health clinics, eye care clinics, behavioral health facilities, etc., employing 50 or more persons are required to designate at least one person to coordinate its efforts to comply and carry out its nondiscrimination mandates under Title II.⁵³ Many public entities identify such person as the “ADA Coordinator” (and often the same person also serves as the public entity’s 504 Coordinator). In addition, if employing 50 or more persons, they are also required to adopt and publish grievance procedures providing for the prompt investigation and resolution of complaints alleging inaccessibility of their buildings, services, policies and procedures or programs.⁵⁴

The Title II regulation contains a broad general nondiscrimination mandate – “[n]o qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs or activities of a public entity, or be subjected to discrimination by any public entity.”⁵⁵ The regulation further provides that a public entity may not:

- (1) deny a *qualified individual* with a disability the opportunity to participate in or benefit from its aid, benefit, or service;⁵⁶
- (2) afford such person with an opportunity to participate in or benefit from its aid, benefit, or service that is not equal to that afforded others;⁵⁷ or

⁵³ 28 C.F.R. § 35.107.

⁵⁴ *Id.*

⁵⁵ 28 C.F.R. § 35.130(a).

⁵⁶ 28 C.F.R. § 35.130(b)(1)(i)

⁵⁷ *id.* § 35.130(b)(1)(ii);

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(3) provide such persons with an aid, benefit, or service that is not as effective in affording them an equal opportunity to gain the same benefit as a person without disabilities.⁵⁸

To achieve these objectives, the regulation requires a public entity to “make reasonable modifications in policies, practices, or procedures when . . . necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.”⁵⁹

A “qualified individual” is one who meets the entity’s essential eligibility requirements, *with or without a reasonable modification*. When a reasonable modification provides the individual with a disability with an “equal opportunity to . . . gain the same benefit,” it provides “meaningful access.” See *Alexander v. Choate*, 469 U.S. 287, 301 (1985).⁶⁰ An exclusion or denial is *by reason of disability* if a reasonable modification exists that would allow the individual to participate in the services or activities.⁶¹ Courts have repeatedly recognized ADA claims when a qualified individual with a disability was put in an unsafe situation, or otherwise caused “greater injury or indignity than” people without disabilities, after a public entity failed to make reasonable modifications. *Sheehan v. City & Cnty. of San Francisco*, 743 F.3d 1211, 1232 (9th Cir.), rev’d in part on other grounds, *City & Cnty. of San Francisco, Calif. v. Sheehan*, 135 S. Ct. 1765 (2015). For instance, the Eighth Circuit Court of Appeals held that an individual who used a wheelchair had stated a claim under the ADA where he was transported in a non-wheelchair-

⁵⁸ *id.* § 35.130(b)(1)(iii).

⁵⁹ 28 C.F.R. § 35.130(b)(7).

⁶⁰ See also 42 U.S.C. § 12131(2).

⁶¹ *Bircoll v. Miami-Dade County*, 480 F.3d 1072, 1081-82 & n.13. (11th Cir. 2007).

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accessible vehicle. *Gorman v. Bartch*, 152 F.3d 907, 913 (8th Cir. 1998). The court explained that the transportation had caused injury and been humiliating, and that “[t]he ‘benefit’ [plaintiff] sought . . . was to be handled and transported in a safe and appropriate manner consistent with his disability.” *Id.* (citing 28 C.F.R. § 35.130(b)(1)). Similarly, in a case involving unsafe transportation of a person in a wheelchair to medical services, a court explained that:

Although plaintiff is not wholly precluded from participating in this service, if he is at risk of incurring serious injuries each time, he attempts to take advantage of outside medical attention, surely he is being denied the *benefits* of this service. The plain language of the ADA demonstrate[s] that the statute was designed to ensure that disabled persons are neither denied access to, nor the *benefits* of services based on their disability.

Allah v. Goord, 405 F. Supp. 2d 265, 280-81 (S.D.N.Y. 2005). It is not necessary that the individual actually suffer an injury, only that the person be at risk of “greater injury or indignity” than a person without disabilities. See *Bane v. Virginia Dep't of Corr.*, No. 12-159, 2012 WL 6738274, at *11, 15 (W.D. Va. Dec. 28, 2012) (citing § 35.130(b)(1) and holding that plaintiff stated ADA claim where he was forced to use a shower that posed a high risk of injury for him, unlike inmates without disabilities).

Nothing in the Title II regulations specifically requires a Title II healthcare facility to ensure the availability and usage of accessible medical or diagnostic equipment. But, for example, if a hospital operated by a state, county, city, village, etc., does not have wheelchair accessible weight scales, and therefore a person with paralysis or mobility disability cannot be weighed when it is clinically necessary to be weighed, then a strong argument can be made that the person was denied the benefits of the hospital’s services under Title II. In this example, the failure to

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have wheelchair accessible weight scales is a failure of the public entity to make reasonable modifications to its policies, practices and procedures with respect to the purchase of weight scales as required by the Title II regulation. Specifically, public entities are required to make reasonable modifications to policies, practices, and procedures where necessary to avoid discrimination, unless the entity can demonstrate that making such modifications would “fundamentally alter” the entity’s services, programs, or activities.⁶² That requirement reflects Congressional recognition that even facially neutral policies and practices can create unnecessary barriers for people with disabilities.⁶³ A “fundamental alteration” defense is highly fact- and context-specific.

Public entities also have specific obligations with respect to service animals,⁶⁴ but that was not always the case. When the Title II regulation was first issued on July 26, 1991, the Department of Justice believed it would have been redundant to include specific provisions in the regulation for public entities specific provisions with respect to accommodating the use of service animals as that requirement fell under the broad “reasonable modification” requirement already in the regulations. However, on July 23, 2012, those requirements were strengthened when the Department of Justice issued a revised Title II regulation that “comport[ed] with [its] legal and practical experiences in enforcing the ADA since 1991.”⁶⁵ Part of those practical experiences included the Department of Justice’s determination that covered entities were

⁶² 28 C.F.R. § 35.130(b)(7).

⁶³ See 42 U.S.C. § 12101(a)(5)

⁶⁴ 28 C.F.R. pt. 35, app. A § 35.104 at 598-99 (2014) (citing 28 C.F.R. § 35.130(b)(7)); see also *id.* pt. 35, app. A § 35.136 at 607;

⁶⁵ 75 Fed. Reg. 56,164 (Sept. 15, 2010).

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“confused regarding their obligations under the ADA with regard to individuals with disabilities who use service animals,” and therefore, the Department added a service animal provision (§ 35.136) to the Title II regulation, which codified and clarified public entities’ existing obligations with respect to service animals.⁶⁶ The provisions virtually mirror the service animal provisions applicable for Title III public accommodations, as discussed below.⁶⁷

A service animal is defined as a “dog,” of any breed or size,” and while not defined as a service animal, the regulation permits the use of a “miniature horse” that is individually trained to assist a person with disability,⁶⁸ but that was not always the case. In *Monkeys and Horses and Ferrets...oh My! Non-Traditional Service Animals Under the ADA*,⁶⁹ the author recounts that when the Department of Justice issued its 1991 ADA regulations it defined a service animal as “any guide dog, signal dog, or other animal individually trained to do work or perform tasks for the benefit of an individual with a disability. . . .”⁷⁰ The Department of Justice had faced a trend towards the use of “wild, exotic, or unusual species, many of which are untrained, as service animals,”⁷¹ among them wild animals (including nonhuman primates born in captivity), reptiles, rabbits, farm animals (including horses, miniature horses, ponies, pigs, and goats), ferrets, amphibians, and rodents.⁷²

⁶⁶ 28 C.F.R. pt. 35, app. A §§ 35.104, 35.136 at 599, 607.

⁶⁷ [28 C.F.R. § 35.136\(a\)](#) .

⁶⁸ 28 C.F.R. [§35.104](#)

⁶⁹ Robert L. Adair, *Monkeys and Horses and Ferrets...oh My! Non-Traditional Service Animals Under the ADA*, 37 N. Ky. L. Rev. 415 (2010).

⁷⁰ Id. citing 28 C.F.R. § 36.104 (1991).

⁷¹ [Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 73 Fed. Reg. 34,508, 34,516 \(June 17, 2008\)](#).

⁷² Robert L. Adair, *Monkeys and Horses and Ferrets...oh My! Non-Traditional Service Animals Under the ADA*, 37 N. Ky. L. Rev. 415 (2010). See also, Disabled World, *Helping Hands Monkey Helpers for Quadriplegics* (Jan. 8, 2009),

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Public entities generally must make modifications to their policies, practices and procedures to permit individuals with disabilities to use their service animals pursuant to the reasonable modification requirement of Title II discussed above. Public entities can ask that a service animal be removed if it is out of control and the animal's handler does not take effective action to control it, or if the animal is not housebroken. If asked for service animal to be removed, the entity must provide the person with a disability opportunity to obtain the services he or she was seeking.⁷³ A service animal is required to have a harness, leash or other tether in less the handlers unable because of a disability to use one or the use of one would interfere with the service animal safe, effective performance of work or tasks, in which case the service animal must be otherwise under the handlers control through voice control, signals or other effective means.⁷⁴ The only permissible questions that can be asked of a person utilizing a service animal is: (1) if the animal is required because of a disability, and (2) what work or task the animal has been trained to perform. those questions should not be asked when it is readily apparent that an animal is trying to do the work or perform tasks for person with a disability.⁷⁵ For example, if the service animal is pulling a person's wheelchair or helping with stability or balance to a person with an observable mobile disability, those questions should not be asked.⁷⁶

A person with paralysis or mobility disability may be accompanied by their service animal in all areas of a healthcare facility with the public are allowed to go,⁷⁷ such as: admissions and

<https://www.disabled-world.com/disability/serviceanimals/monkey-helpers.php>. (Last accessed, October 30, 2020).

⁷³ 28 C.F.R. § 35.136(a) – (c).

⁷⁴ 28 C.F.R. § 35.136(d).

⁷⁵ 28 C.F.R. § 35.136(f).

⁷⁶ *Id.*

⁷⁷ 28 C.F.R. § 35.136(g).

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discharge offices, the emergency room, inpatient and outpatient rooms, examining and diagnostic rooms, clinics, rehabilitation therapy areas, the cafeteria and vending areas, the pharmacy, restrooms, and all other areas of the facility where health care personnel, patients, and visitors are permitted without taking added precautions.⁷⁸

A hospital thus improperly discriminates if it "fails to make reasonable accommodations for a person with a service animal."⁷⁹ A hospital need not allow an individual to use her service animal if it would fundamentally alter the nature of its service, program, or activity, or if it would pose a direct threat to the health or safety of others.⁸⁰ Consistent with Center for Disease Control and Prevention guidance,⁸¹ it is generally appropriate to exclude a service animal from limited-access areas that employ general infection-control measures, such as operating rooms, burn units, intensive care units, pediatric intensive care units and other areas in the hospital where either the public is not fully allowed to go or for infectious control reasons.

The United States Court of Appeals for the Seventh Circuit recently ruled that the ADA's regulations do not require public entities to permit hogs in public spaces after the City of Chicago denied a person with an emotional support hog from entering onto the City's beaches and public parks with his hog.⁸² People objecting to the presence of his hog harassed him and it caused such

⁷⁸ Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 75 FR 56236-01 2010 WL 356-1890, September 15, 2010

⁷⁹ See *C.L. v. Del Amo Hosp.*, [2019 BL 332246, 6](#) (C.D. Cal. Sept. 03, 2019) citing *Tamara v. El Camino Hospital*, [964 F. Supp. 2d 1077](#), [1083](#) (N.D. Cal. 2013).

⁸⁰ 28 C.F.R. §§ 35.130(b)(7), 35.139; see 28 C.F.R. pt. 35, app. A §§ 35.104, 35.136 at 600, 608.

⁸¹ CDC. *Guidelines for Environmental Infection Control in Health-Care Facilities: Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC)* (2003) Last Updated: July 2019. Pp. 120-126. *MMWR* 2003; 52 (No. RR-10): 1-48. Available at: <https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf> (last accessed, October 30, 2020).

⁸² *Mayle v. City of Chicago*, [803 Fed. Appx. 31, 32](#), [2020 BL 159165, 2](#) (7th Cir. 2020)

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a public disruption the police were called to the scene. The court relied upon the facts that “service animals” under the Title II regulations are only dogs or miniature horses, but not to any other species of animal, trained or untrained, wild or domestic.

Title III Regulations Applicable to Public Accommodations

Title III of the ADA addresses discrimination in public accommodations and services operated by private entities.⁸³ A “public accommodation” is defined as a private entity that owns, leases (or leases to) or operates a place of public accommodation.⁸⁴ A “place of public accommodation” is a facility, operated by a private entity whose operations affect commerce, which includes the professional office of a healthcare provider, hospital or other service establishment.”⁸⁵ Thus, almost every healthcare facility that opens its doors to the public, that is not owned by a state, city, county or other government unit is considered “place of public accommodation” and is subject to the requirements of the Title III regulation.

The significant exception is that the ADA, and the Title III regulation, does not apply to healthcare facilities owned and operated by religious entities, of which there are numerous. In 2020, Catholic healthcare was the nation’s largest group of not-for-profit health care providers, with 668 hospitals and 1,666 continuing care facilities throughout the country, and according to the Catholic Health Association of the United States, more 1 out of every 7 patients in the United States were cared for in a Catholic healthcare facility.⁸⁶ Section 307 of the ADA expressly provides that it shall not apply to religious organizations or entities controlled by religious organizations,

⁸³ 42 U.S.C. §§ 12181-89.

⁸⁴ 28 C.F.R. § 36.104.

⁸⁵ *Id.*

⁸⁶ U.S. Catholic Healthcare 2020. Available at: <https://www.chausa.org/about/about/facts-statistics>

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including places of worship.⁸⁷ This exemption is very broad, encompassing a wide variety of situations. Even when a religious organization carries out activities that would otherwise make it a public accommodation, the religious organization is exempt from ADA coverage. Just as religious entities are permitted to hire only people of their faith under Title VII of the Civil Rights Act of 1964,⁸⁸ religious entities are not required to follow the mandates of the ADA. For example, the ADA provides that discrimination under Title III includes a failure to make reasonable modifications in policies, practices, or procedures that are necessary to ensure nondiscriminatory treatment to persons with disabilities.⁸⁹ While a public accommodation is required to make only modifications that are “reasonable” or that would not “fundamentally alter” the nature of the services provided,⁹⁰ any evaluation of these factors for a service, like healthcare, provided by a religious organization could require scrutiny of religious practices and beliefs, as well as the finances of the organization. Forcing religious entities to open their activities to government scrutiny could result in impermissible governmental interference with religious practices.⁹¹

In 2018, the *Kaiser Family Foundation*, reported there were a total of 2,937 nonprofit and 1,296 for-profit hospitals in the United States, with Texas leading the way with 523 hospitals, followed by California with 359 hospitals.⁹² Those hospitals, like any other healthcare facility not

⁸⁷ 42 U.S.C. § 12187; 28 C.F.R. Pt. 36, App. B

⁸⁸ 42 U.S.C. 2000e-1. Section 702 provides that Title VII “shall not apply * * * to a religious corporation, association, educational institution, or society with respect to the employment of individuals of a particular religion.”

⁸⁹ 42 U.S.C. 12182(b)(2)(A)(ii); see also 28 C.F.R. 36.302(a) (1994).

⁹⁰ 42 U.S.C. 12182(b)(2)(A)(ii); 28 C.F.R. 36.302(a) (1994),

⁹¹ See *Forest Hills Early Learning Ctr., Inc. v. Grace Baptist Church*, 846 F.2d 260, 263 (4th Cir. 1988), cert. denied, 488 U.S. 1029 (1989), addressing the religious exemption under Title VII of the Civil Rights Act of 1964.

⁹² Kaiser Family Foundation, *Hospitals by Ownership Type 2018*, supra note 103.

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operated by religious entity or belonging to a public entity, must ensure they comply with the nondiscrimination mandates of the Title III regulations which, among other things, imposes a general obligation requiring that “no individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages or accommodations of any place of public accommodation by any private entity that owns, leases (or leases to) or operates a place of public accommodation.”⁹³

Unlike the Section 504 regulation, the Title III regulations are lengthy and detailed. Like the Title II regulation, nothing in the Title III regulation explicitly states that public accommodations are required to provide “Accessible Healthcare.” That is an obligation, however, implicit under the general nondiscrimination mandate and a series of specific mandates, to include the restriction on imposing or applying eligibility requirements that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying, among other things, the services, facilities, privileges or accommodations of a healthcare provider.⁹⁴ Thus, for example, a behavioral health hospital may not establish a policy requiring, as a condition for inpatient services, that the patient be able to walk, and a hospital may not condition treatment of a patient, even in circumstances of crisis where medical rationing is required, on the patient’s ability to walk and talk.

Accessible Healthcare is also implicit under healthcare providers’ specific obligation, subject to its fundamental alteration defense, to make reasonable modifications to its policies,

⁹³ 28 C.F.R. § 36.201(a), unless such criteria can be shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered.

⁹⁴ 28 C.F.R. §36.301 (a)

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practices and procedures, when the modifications are necessary to afford, among other things, its services, facilities, privileges, advantages, or accommodations to individuals with disabilities.⁹⁵ Extending additional time for appointments when a person with paralysis or mobility disability needs assistance completing admission paperwork or dressing or undressing for an appointment; scheduling the use of wheelchair examination rooms for appointments with persons with paralysis or mobility disability; requiring, when it is clinically indicated, medical staff to always weigh patients with paralysis or mobility disabilities who cannot safely and independently stand on a traditional weight scale, are all examples of how compliance with the specific obligation to modify policy, practices and procedures can be used to achieve accessible healthcare. It is important to note that unlike the Section 504 or the Title II regulations, the Title III regulation does not require the appointment of one or more persons to assume responsibility for compliance with the regulation.

Healthcare providers are also required to modify their policies, practices and procedures to allow service animals to accompany a patient anywhere within the hospital where the public is able to go, identical to the Title II regulation requirements and the limitations discussed above. While a dog is the only type of service animal permitted under the regulation, the regulation requires a healthcare provider to also reasonably modify its policies, practices and procedures to permit the use of a “miniature horse” that has been individually trained to do work or perform tasks for the benefit of the person with a disability.⁹⁶ While a healthcare provider must accept a dog of any size and any breed, in reasonably modifying its policies, practices and procedures, it

⁹⁵ 28 C.F.R. §36.302(a)

⁹⁶ 28 C.F.R. §36.302(a)(9).

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can take into account the type, size and weight of the miniature horse; whether the facility can accommodate those features; whether the handler has sufficient control of the miniature horse; whether it is housebroken; and whether its presence in the facility compromises legitimate safety requirements that are necessary for safe operations.⁹⁷

While reasonable modifications to a healthcare providers' policies, practices and procedures are critical to the provision of Accessible Healthcare for persons with paralysis or mobility disabilities, it is healthcare providers' specific obligation to remove architectural barriers, when "readily achievable," that is essential to the provision of Accessible Healthcare.⁹⁸ A healthcare provider modifying its policies, for example, to allow for extra time for a person with paralysis to receive assistance in completing paperwork and undressing for a physical examination is meaningless if that person cannot enter the building where the healthcare provider is located or cannot enter the examination or treatment room because of a narrowed entry door.

Like with the Title II regulation, the Title III regulation does not specifically address accessible medical of equipment and furniture. In 1991, when the Title III regulation was drafted, there was no mention of accessible medical equipment and furniture. The Department of Justice has, however, consistently, when interpreting its regulation, maintained that accessible equipment and furniture is covered in its modification of policies, practices and procedures and barrier removal requirements in Sections 36.302 and 36.304 of its Title III regulation.⁹⁹ It also

⁹⁷ 28 C.F.R. §36.302(a)(9)(i)&(ii).

⁹⁸ 28 C.F.R. §36.304(a)

⁹⁹ 75 FR 56236, 56315 Federal Register (September 15, 2010). *See also*, 28 CFR part 36, app. B (2009) ("Proposed Section 36.309 Purchase of Furniture and Equipment").

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passed up an opportunity to include specific provisions in its revision to the regulations in 2010 as there were at that time, no appropriate accessibility standards applicable to the many types of equipment.¹⁰⁰ While the Department of Justice relies on its interpretation of its own rules, which as a point of law is given judicial deference, the absence of specific language unequivocally requiring the provision of accessible medical and diagnostic equipment provides cover for healthcare providers who desire to skirt their legal obligations to provide Accessible Healthcare and is a significant factor for the absence of Accessible Healthcare for persons with paralysis and mobility disabilities.

People with disabilities experience disparities in accessing primary and preventative care. For example, 61.4% of women with disabilities reported having mammograms while 74.4% of women without disabilities received this test.¹⁰¹ For pap tests the numbers are even more disparate, where 64.6% of women with complex disabilities received pap tests compared to 82.5% of women with no impairments.¹⁰² Furthermore, men with disabilities were found to be 19% less likely to report a prostate-specific screening test.¹⁰³ While obesity is a leading health indicator¹⁰⁴ and adults with disabilities have a 58% higher rate of obesity than those without

¹⁰⁰ *Id.*

¹⁰¹ Altman, B. M., & Bernstein, A. (2008). Disability and health in the United States, 2001-2005.

¹⁰² Mudrick, N. R., & Schwartz, M. A. (2010). Health care under the ADA: A vision or a mirage? *Disability and Health Journal*, 3(4), 233-239. doi:<https://doi.org/10.1016/j.dhjo.2010.07.002>

¹⁰³ Ramirez, A., Farmer, G. C., Grant, D., & Papachristou, T. (2005). Disability and preventive cancer screening: results from the 2001 California Health Interview Survey. *American Journal of Public Health*, 95(11), 2057-2064.

¹⁰⁴ Secretary's Advisory Committee on national Health Promotion and Disease Prevention Objectives for 2030. *Recommendations for Developing Objects, Setting Priorities, Identifying Data Needs, and Involving Stakeholders for Health People 2030*. Washington D.C.: U.S. Department of Health and Human Services; 2017. https://www.healthypeople.gov/sites/default/files/Advisory_Committee_Objectives_for_HP2030_Report.pdf.

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disability,¹⁰⁵ A June 2020 study in the *Disability and Health Journal* cites the paucity of accessible weight scales and height adjustable examination tables as contributing to physicians' inability to properly counsel and manage obesity in patients with physical disabilities.¹⁰⁶ The study is remarkable for several reasons, among them the finding of physicians' reluctance to transfer obese patients onto examination tables or to provide diagnostic testing.¹⁰⁷

The requirement to remove architectural barriers is not absolute. If a healthcare provider can demonstrate that the barrier removal is not "readily achievable" – that is, cannot be accomplished without much difficulty or expense – then the provider is excused from removing the barrier at issue.¹⁰⁸ Proving that something is not readily achievable is not easy. There are a number of factors used to evaluate whether removal of a particular barrier is "readily achievable:"

- (1) the nature of the cost of the action;
- (2) the overall financial resources of the facility or facilities involve;
- (3) number of persons employed at such facility;
- (4) the effect on expenses and resources;
- (5) the impact of such action on the operation of the facility; the overall financial resources of the covered entity; and
- (6) the overall size of the business of the covered entity, among other factors.¹⁰⁹

¹⁰⁵ Centers for Disease Control and Prevention. Disability and Obesity. Published <https://www.cdc.gov/ncbddd/disabilityandhealth/obesity.html>.

¹⁰⁶ Agaronnik ND, et al., Accommodating patients with obesity and mobility difficulties: Observations from physicians. *Disability and Health Journal*, <https://doi.org/10.1016/dhjo.2020.100951>.

¹⁰⁷ *Id.*

¹⁰⁸ [42 U.S.C. § 12181\(9\)](#);

¹⁰⁹ See, *Garthright-Dietrich v. Atlanta Landmarks, Inc.*, [452 F.3d 1269](#), [1273](#) (11th Cir. 2006).

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The assessment is a fact intensive inquiry that absent agreement between the parties, it is determined by a court.¹¹⁰ Note that none of the factors include the amount of reimbursement for a particular procedure. In many instances healthcare providers decline a request to acquire a wheelchair accessible weight scale, lift equipment or a height adjustable examination table so to provide a complete physical examination to a person with paralysis or mobility disabilities who is not able to independently transfer from his or her wheelchair onto an examination table because the cost of acquiring such equipment outweighs the amount of money the provider is paid for the specific treatment or examination. That is discriminatory. Regardless of what Medicare, Medicaid or a private health insurance company pays the physician, even if it is an amount less than the cost of that equipment, the healthcare provider is discriminating against the patient if it refuses to acquire or make available that equipment when necessary. Even if, however, a healthcare provider is able to demonstrate that the requested barrier removal is not readily achievable, they nevertheless have an obligation to provide its services through alternative methods if those methods are readily achievable.¹¹¹

C. Accessibility Standards for Accessible Design

Discrimination also includes a failure to design or construct facilities, or make alterations to the maximum extent feasible, that are “readily accessible to and usable by individuals with disabilities . . . in accordance with standards set forth or incorporated by reference in regulations”

¹¹⁰ *Access Now, Inc. v. S. Fla. Stadium Corp.*, [161 F. Supp. 2d 1357](#), [1371](#) (S.D. Fla. 2001).

¹¹¹ 28 C.F.R. § 36.305.

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issued under Title III.¹¹² The ADA directs the United States Attorney General to promulgate implementing regulations and, with respect to physical access, to ensure consistency with the minimum guidelines and requirements of the Architectural and Transportation Barriers Compliance Board, now known as the Access Board.¹¹³ The Title III regulation details how places of public accommodation and commercial facilities are “to be designed, constructed, and altered in compliance with the accessibility standards” set out in the regulations.¹¹⁴

The Department of Justice has promulgated two sets of accessibility standards. The 1991 Standards were published on July 26, 1991 and are contained in Appendix D of the Title III regulation.¹¹⁵ The 1991 Standards are based on the Access Board’s ADA Accessibility Guidelines (1991 ADAAG), which were published the same day. The Access Board issued updated ADA Accessibility Guidelines in 2004 (2004 ADAAG), with the goal of harmonizing existing federal accessibility standards and model building codes.¹¹⁶ The Department of Justice promulgated the 2010 Standards on September 15, 2010. The ADA Standards for Accessible Design (ADA Standards), comprising both the 1991 Standards and 2010 Standards, set out the relevant accessibility standards for evaluating compliance with the statute and regulation.¹¹⁷

The ADA Standards cover “fixed or built-in elements of buildings, structures, site improvements, and pedestrian routes or vehicular ways located on a site.”¹¹⁸ They establish the minimum scoping and technical requirements for a facility or part thereof to be “readily

¹¹² 42 U.S.C. § 12183(a)(1)-(2).

¹¹³ *Id.* § 12186(b)-(c).

¹¹⁴ 28 C.F.R. § 36.101(a).

¹¹⁵ 28 C.F.R. pt. 36, App. D.

¹¹⁶ *See* 36 C.F.R. pt. 1191.

¹¹⁷ *See* 42 U.S.C. §§ 12183, 12186; 28 C.F.R. §§ 36.102; 36.304(d) and Subpart D.

¹¹⁸ 28 C.F.R. § 36.406(b); *see* 28 C.F.R. pt. 36, app. A at 860-61 (Section 36.406(b)).

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accessible to and usable by individuals with disabilities.”¹¹⁹ The ADA Standards do not address, however, every conceivable disability impact in a physical space. Rather, they are designed to provide a convenient degree of access for most people with disabilities to approach, enter, and use a facility.¹²⁰

Hospitals and other medical facilities, whether owned and operated by public entities or public accommodations must comply with the specific ADA Standards addressing paths of travel, accessible routes, general site and building elements, plumbing elements, built-in elements, among others. In addition, ADA Standards have specific minimum requirements affecting medical facilities. In facilities not specializing in treating “conditions that affect mobility,” at least 10%, but no fewer than one, of the patient sleeping rooms must meet the turning space, ground-floor clearance, and the specific requirements for toilet bathing rooms.¹²¹ “Conditions that affect mobility” include conditions requiring the use or assistance of a brace, cane, crutch, prosthetic device, wheelchair, or powered mobility aid; arthritic, neurological, or orthopedic conditions that severely limit one’s ability to walk; respiratory diseases and other conditions which may require the use of portable oxygen; and cardiac conditions impose significant functional limitations.¹²² In facilities specializing in treating conditions that affect mobility, 100% of the patient sleeping

¹¹⁹ 2010 Standards, Overview, § 101.1; *see generally* 1991 Standards, § 4 (setting out scope and technical requirements for accessible elements and spaces).

¹²⁰ *See* H. R. Rep. No. 101-485, pt. 2, at 117-18 (1990) (noting that “the term [readily accessible to and usable by] contemplates a high degree of convenient accessibility, entailing accessibility of parking areas, accessible routes to and from the facility, accessible entrances, usable bathrooms and water fountains, accessibility of public and common use areas, and access to the goods, services, programs, facilities, accommodations, and work areas available at the facility”).

¹²¹ 2010 Standards §§ 223.2 .1 & 805.

¹²² 2010 Standards § 805.1.6.

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rooms shall provide the mobility features described above.¹²³ Accessible sleeping rooms should be dispersed throughout all medical specialties, such as obstetrics, orthopedics, pediatrics and cardiac care. When not sufficiently dispersed, persons with disabilities are denied full and equal medical care as they are often placed in an accessible room in an area that is not medically appropriate for his or her condition and is thus denied quick access of staff with expertise in that medical specialty and specialized equipment.

Healthcare providers also are specifically required to provide appropriate auxiliary aids and services to ensure that no person with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services.¹²⁴ Examples of auxiliary aids and services, include on-site American sign language interpreters, sign language interpreters through video remote interpreting equipment, Brailled materials, materials in large print, etc.¹²⁵ The provision of auxiliary aids and services is often necessary to provide a person requiring such aids and services and equal opportunity to participate in the services offered by a healthcare provider and in their own healthcare, and may be necessary for healthcare providers to satisfy the requirement of achieving effective communication with persons with disabilities and their companions.¹²⁶ By far, the failure of healthcare providers to provide auxiliary aids and services necessary to achieve effective communication has been the most enforced provision of the Title III regulation.

¹²³ 2010 Standards § 223.2.2.

¹²⁴ 28 C.F.R. §36.303(a)

¹²⁵ 28 C.F.R. §36.303(b)

¹²⁶ 28 C.F.R. §36.303(c)

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D. Section 1557 of the Affordable Care Act Regulations

In 2016, HHS promulgated regulations specifically for Section 1557, which effectively expanded the reach of the four historic acts – Title VI of the Civil Rights Act of 1964;¹²⁷ Title IX of the Education Amendments of 1972;¹²⁸ the Age Discrimination Act of 1975;¹²⁹ and Section 504 of the Rehabilitation Act of 1973¹³⁰ – into new areas, such as health plan administration and health insurance policy terms; reinterpreted key concepts, such as sex discrimination; and modernized other areas, such as by adding new rules on limited English proficiency and website accessibility. That new antidiscrimination protection prohibited not only intentional discrimination but also facially neutral policies and practices that have an unjustified disproportionate impact upon persons because of their race, gender, disability, age or religion. Section 1557 does not define prohibited discrimination but does adopt language from Title VII that is mirrored in Title IX, Section 504 and the Age Discrimination Act, providing that an individual shall not, on the grounds prohibited by the statute be “excluded from participation in, be denied the benefits of, or be subjected to discrimination under “any healthcare program or activity.”¹³¹

The Section 1557 regulation applies to “any health program or activities, any part of which is receiving Federal financial assistance” from HHS.¹³² Thus, like the application of the Section 504 regulation, healthcare providers participating in Medicare, Medicaid or any other federal health care program are required to comply with Section 1557. Of critical importance, there was no

¹²⁷ 42 U.S.C. § 2000d et seq.

¹²⁸ 20 U.S.C. § 1681 et seq.

¹²⁹ 42 U.S.C. § 6101 et seq.

¹³⁰ 29 U.S.C. § 794

¹³¹ See 42 U.S.C. § 12132 (2006); accord 42 U.S.C. § 2000h-2, 29 U.S.C. § 701, 42 U.S.C. § 2000d-2.

¹³² See, *Id.*

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religious exemption under Section 1557. Meaning all faith-based healthcare systems who were otherwise deliberately excluded from the nondiscrimination requirements of Title III of the ADA, were subject to Section 1557 if they received Federal financial assistance from HHS. That said, faith-based healthcare providers who conscientiously opposed complying with Section 1557 had to rely on the protections afforded them under the Religious Freedom Restoration Act.

Healthcare providers subject to Section 1557 that employ 15 or more persons were required to designate at least one person to coordinate its efforts to comply and carry out its responsibilities under Section 1557, including the investigation of any grievance communicated to it alleging noncompliance with its nondiscrimination mandates.¹³³ In addition, if a healthcare provider employs 15 or more persons they are also required to adopt grievance procedures with appropriate due process standards that provide for the prompt and equitable resolution of any complaints alleging violation of Section 1557.¹³⁴ With respect to prohibited conduct affecting persons with disabilities, the requirements of Section 1557 were consistent with the existing requirements under Section 504 and Title II and Title III of the ADA, except that the requirements of Section 1557 imposed heightened communication access requirements for healthcare providers to achieve effective communication with persons who are Deaf, hearing-impaired, blind or otherwise visually impaired,¹³⁵ and, as the ACA incorporated the requirements of Title VI of the Civil Rights Act of 1964 and Section 504, it made available compensatory damages and not just injunctive relief for violations of Section 1557.¹³⁶

¹³³ 45 C.F.R. § 92.7(a).

¹³⁴ 45 C.F.R. § 92.7(b).

¹³⁵ 45 C.F.R. § 92.202(a).

¹³⁶ 45 C.F.R. § 92.301.

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On June 12, 2020, HHS considerably revised Section 1557 after a series of actions taken by the Trump Administration to minimize the effects of the regulations. With the revisions to Section 1557, HHS eliminated certain provisions of the 2016 regulation that it believed exceeded the scope of its authority delegated by Congress, were duplicative or confusing, imposed substantial unanticipated burdens or imposed burdens that outweighed their anticipated benefits, while asserting to continue to vigorously enforce federal civil rights law prohibiting discrimination on the basis of race, color, national origin, its ability, age and sex in healthcare.¹³⁷ The revised Section 1557 rule retained the protection to ensure physical access for persons with disabilities to healthcare facilities.¹³⁸

¹³⁷ See, 85 FR 37160 (June 19, 2020); and HHS press release, HHS Finalizes Rule on Section 1557 Protecting Civil Rights in Healthcare, Restoring the Rule of Law, and Relieving Americans of Billions in Excessive Costs, <https://www.hhs.gov/about/news/2020/06/12/hhs-finalizes-rule-section-1557-protecting-civil-rights-healthcare.html>.

¹³⁸ 45 C.F.R. § 92.103.