JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

November 13, 2023

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Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted via regulations.gov

Re: Notice of Proposed Rulemaking on Discrimination on the Basis of Disability in Health and Human Service Programs or Activities. Docket No: 2023-19149, RIN: 0945-AA15

Justice in Aging appreciates the opportunity to comment on this notice of proposed rulemaking (NPRM) implementing Section 504 of the Rehabilitation Act of 1973. We thank the Department of Health and Human Services (HHS) Office for Civil Rights (OCR) for this much needed rulemaking that will strengthen civil rights for people with disabilities, including older adults.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable healthcare, economic security, and the courts for older adults with limited resources. We focus our efforts primarily on those who have been marginalized and excluded from justice such as older adults of color, older women, LGBTQ+ older adults, older adults with disabilities, and older adults who are immigrants or have limited English proficiency. Justice in Aging has decades of experience with Medicare and Medicaid and improving integration of both programs for people dually eligible. We also have extensive expertise in Medicaid home- and community-based services (HCBS) policy, litigation to enforce the integration mandate under the Americans with Disabilities Act, and other civil rights advocacy related to this rulemaking.

Justice in Aging strongly supports HHS's stated goals of this rulemaking and believe the proposed regulations will advance those objectives. As a threshold matter, we encourage HHS to include more examples of older adults with disabilities and people with other intersectional identities in the final rule. Such examples can illustrate how this rule's protections apply to people who may not identify or be identified by recipients of federal financial assistance (hereinafter "covered entities") as having a disability. Examples of what disability discrimination looks like for someone with multiple marginalized identities can also more clearly demonstrate the critical importance of these protections. We also recommend further discussion in the final rule of the relationship between these Section 504 regulations and the pending regulations implementing Section 1557 of the Affordable Care Act.

Our comments primarily focus on ways to strengthen the NPRM provisions addressing discrimination in medical treatment and integration. We also address the general prohibitions against discrimination, accessible medical equipment, and some of the specific questions the NPRM poses. We are signatories to comment letters submitted by the Consortium for Constituents with Disabilities (CCD) and by the Center for Medicare Advocacy.

Medical Treatment (§ 84.56)

Justice in Aging strongly supports the new proposed provisions prohibiting discrimination against people with disabilities in medical treatment. These new provisions will provide important protections for older adults with disabilities who experience intersecting discrimination based on their age and disability.

Organ Transplantation

We appreciate HHS's recognition that people with disabilities are often improperly denied organ transplants due to their disability, even when their disability is unrelated to the likelihood of successful transplantation. Older adults with disabilities, and particularly individuals of color, are less likely to be placed on organ transplant lists.[1]

The proposed requirement under § 84.68(b)(7) for providers to make reasonable modifications for individuals with disabilities is crucial to ensuring discriminatory views do not impact decisions related to the success of organ transplants.[2] We recommend that HHS include explicit discussion of this provision's application to organ transplantation in the final rule. We do want to note that the policy statement from the American Society of Transplant Surgeons' policy statement, which HHS cites, states that patients will not be discriminated against "solely due to the presence of a disability or handicap." The use of "solely" is concerning because a disability may have some impact on the success of the procedure but not enough to make the procedure unsuccessful. For example, a patient's disability may affect the type of post-operative care they receive. Here a provider may not be making medical decisions "solely" based on the disability, but could be making assumptions about the impact of the patient's disability on post-operative care when making medical decisions. In situations where the provider is considering the individual's post-operative care, the provider must factor in needed accommodations if considering disability as a clinical factor. Therefore, we recommend additional language in the preamble to the final rule clarifying that when considering disability as a clinical factor in organ transplantation, the clinical provider should expressly include needed accommodations that a person with a disability may need.

Life Sustaining Treatment

Strong protections for individuals seeking life sustaining treatment is critical. Ableist and ageist assumptions prevent older adults and people with disabilities from accessing necessary treatments. This is especially detrimental for the growing number of older adults with disabilities. Older adults age 65 and up are the fastest growing age demographic.[3] Approximately 70% of older adults have at least one disability, the most common of which are ambulatory, cognitive, and independent living-related disabilities.[4] As people with disabilities age, they become even more susceptible to discriminatory assumptions both due to their age and disability when accessing life-saving care.

We recognize Section 504 does not bar providers from making judgments about medical futility so long as those determinations are not made based on discriminatory assumptions about the disability. The final rule should explicitly require providers to factor disability accommodations when making determinations about medical futility. The final rule should also include examples of such accommodations when making decisions regarding medical futility.

The proposed rule cites several policy statements from medical groups instructing providers to apply a very narrow definition to medical futility. As they noted, broad interpretations of medical futility can inaccurately invite controversial value judgment on the individual's quality of life. Although the proposed rule includes prohibitions against value-based assumptions about an individual's quality of life, a more concrete definition of medical futility is needed. Without more clarity, providers may not realize

[1] Nat'l Academies of Sciences, Engineering, and Medicine, Realizing the Promise of Equity in the Organ Transplantation System (2022).
[2] This is also consistent with the ADA's requirement for reasonable modifications in policies or procedures as necessary to provide nondiscriminatory treatment. 42 U.S.C. § 12182(b)(2).
[3] U.S. Census Bureau, 1 in 6 people in the United States were 65 and Over (2023).
[4] Pew Research Center, 8 Facts about Americans with Disabilities (2023).

that by making medical futility determinations, they are inviting biased assumptions about the person's disability. We strongly recommend the final rule include a narrow definition of medical futility, based on whether the objective medical evidence shows zero likelihood that the treatment will achieve the intended physiological goal.

Crisis Standards of Care

We strongly support addressing discrimination in crisis standards of care (CSCs) in this rulemaking. During the COVID-19 pandemic, people with disabilities including older adults and those living at the intersection of disability and other marginalized identities, experienced life-threatening discrimination when accessing healthcare. Justice in Aging, along with our disability and aging partners, filed complaints with HHS OCR seeking to prohibit these discriminatory practices, which OCR eventually issued guidance prohibiting such practices.[5] The proposed rule discusses prohibitions of categorical exclusions and long-term survivability after hospitalization, but fails to include other discriminatory practices cited in OCR's guidance.

For example, several CSCs included assessments for determining prognosis when assigning scarce resources. One such assessment, Sequential Organ Failure Assessment (SOFA), assigns less favorable scores for underlying disabilities rather than worsening prognosis.[6] The Glasgow Coma Score (GCS) is one part of the SOFA assessment for evaluating neurological conditions, but does not factor someone's underlying neurological condition when determining disease prognosis. OCR in its guidance included the need for reasonable accommodations to prognostic scoring systems like SOFA and GCS so that the individual's disability serves as the benchmark and prognosis can be assessed based on that benchmark.[7] OCR also prohibited providers form steering individuals into life-withholding agreements like Do-Not-Resuscitate (DNR) orders and advance planning documents, nor could providers require such agreements prior to receiving care.[8] Providers also cannot consider the individual's resource usage as a factor for resource allocation.[9]

Justice in Aging has also strongly advocated against the use of age as a tiebreaker if two individuals have similar prognoses and assessment scores.[10] These tiebreakers always harm older individuals, sometimes even if there is only a marginal difference in age. They are also based on generalized assumption about older adults' life expectancy instead of relying on survivability based on individualized clinical assessments. While this proposed rule is specific to disability protections, age-based discrimination like the use of tiebreakers greatly jeopardizes aging adults with disabilities seeking treatment. As noted above, approximately 70% of older adults have at least one disability. Being denied care, due to age and disability, contradicts the basic civil rights protections behind Section 504. The final rule should not implicitly allow other forms of discrimination to occur by neglecting to prohibit tiebreakers in medical rationing decisions. Instead, providers should rely on additional individualized clinical determinations or randomized allocation if necessary.

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[5] Justice in Aging, Older Adults and People with Disabilities Challenge Discriminatory Surge Care Guidelines in COVID-19 Hotspots Arizona and Texas (2020).
[6] Justice in Aging, Combatting Discriminatory Crisis Standards of Care (2020).
[7] HHS Office for Civil Rights, Civil Rights and COVID-19 (last visited Nov 13, 2023).
[8] *Id.*
[9] *Id*.
[10] *Supra* note 6.

Although the Public Health Emergency (PHE) has ended, CSCs can still be activated for a variety of reasons, meaning people with disabilities and older adults could still be harmed by discriminatory CSCs.[11] It is imperative the final Section 504 rule include the following prohibitions in the final rule:

- Use of categorical exclusions;
- Determinations of long-term survivability beyond the acute hospitalizing illness or injury;
- Use of assessment that do not provide modifications or accommodations for disabilities; Examples include the Sequential Organ Failure Assessment (SOFA) and Glasgow Coma Score (GCS);
- Steering individuals into Do-Not-Resuscitate (DNR) orders or making DNRs a condition of receiving services;
- Consideration of patient's resource intensity or usage;
- Re-allocation of the individual's personal equipment;
- Use of age as a "tiebreaker."

Participation in Clinical Research

We suggest HHS include additional language explaining the importance of representation and intersectionality into the final rule. People with disabilities, and particularly those belonging to multiple identities like older adults and people of color, are often excluded from clinical research. For example, people with certain disabilities and some older adults were barred from participating in clinical trials for the COVID-19 vaccines.[12] Although not explicitly barred, communities of color are also often excluded from research studies.[13] These groups often experience worse health outcomes, and yet the efficacy of treatments and vaccines for these groups are not included in clinical research further worsening health inequities for the most marginalized populations.

Nondiscriminatory Criteria

As discussed above, SOFA and GCS scores discriminate against people with disabilities by deprioritizing them for treatment due to the improper consideration of their disability as part of their prognosis. We strongly urge that the final rule includes, as part of the nondiscriminatory criteria, the requirement for reasonable modifications when using assessment tools like SOFA and GCS scores to ensure tools are accurately measuring disease prognosis and not the underlying disability.

Scope of discrimination prohibited (§ 84.56(a))

We strongly support the broad application of this proposed rule. However, the rule makes a distinction between an individual seeking care for the disability or for another reason not based on their disability. This distinction is not meaningful to individuals with disabilities who are denied care. Discriminatory treatment is harmful to the whole person, even if the treatment sought is distinct from the disability. Further the proposed rule already states that providers may deny treatment if the decision is not based

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[11] Nat'l Academies of Sciences, Engineering, and Medicine, Crisis Standards of Care: A Toolkit for Indicators and Triggers, (2013).

[12] U.S. Dep't of Health and Human Services, Food and Drug Administration, Development and Licensure of Vaccines to Prevent COVID-19 Guidance for Industry, (2023); Bukan et al., Exclusion of Older Adults and Immunocompromised Individuals in Influenza, Pneumococcal, and COVID-19 Vaccine Trials Before and After the COVID-19 Pandemic, *Aging Clinical and Experimental Research* (Apr. 7, 2023).

[13] KFF, Racial Diversity within COVID-19 Vaccine Clinical Trials: Key Questions and Answers (2021).

on any value judgments, bias, or other discriminatory belief. Therefore, we find this distinction unnecessary and contradictory to Section 504's broad application.

Denial of medical treatment (§ 84.56(b)(1))

The proposed rule as written suggests that individuals with disabilities who are denied medical treatment would need to prove one of the listed three bases for discrimination. However, a covered entity could deny care for a reason not listed, but still based on disability, like utilization management, low reimbursement, and budgetary restraints. We recommend broadening the reasons a provider may deny treatment to clarify that all discriminatory denials are prohibited.

We appreciate the example of a person with Alzheimer's in the preamble discussion of this section to illustrate how this rule applies to older adults with disabilities. We encourage HHS to include this example in the final rule as well.

Provision of medical treatment (§ 84.56 (b)(3))

We recommend removing reference to "ease of administration" when determining treatment provided to people with disabilities. Individuals may need alternative forms of treatment due to their disability, and those alternative forms may be more difficult to administer. For example, providers may not be able to examine a patient with limited mobilities with "ease." They may require reasonable accommodations such as specialized equipment or additional assistance for examination or imaging. Under the current language, providers could, instead of offering those accommodations, only offer sedation to ease any discomfort. A particular concern for older adults and anyone with a cognitive disability is the inappropriate prescribing of antipsychotics in nursing facilities to "ease" the provision of care.[14] We are concerned that this language could undermine both the obligations to provide reasonable accommodations and to obtain informed consent.

Additionally, the distinction is unclear between whether disability "impairs the effectiveness" of the treatment sought or "has a medical effect on the condition to which treatment is directed." We suggest additional clarification between these two exceptions.

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

People with dementia and other disabilities are often not offered counseling or other treatments that people without disabilities would be offered. Prescribing of antipsychotic or other medication as chemical restraints as mentioned above is one example that we recommend HHS include in the final rule.

People with disabilities, and particularly older adults, women, and people of color with disabilities, often receive little or no treatment for seemingly subjective symptoms like pain or fatigue.[15] Providers often impose bias, either explicitly or implicitly, on individuals belonging to these identities by minimizing their symptoms. Older adults with disabilities may have their concerns dismissed as "normal" to aging and/or their disability. This can lead to missed diagnoses and delayed treatment. The indignity individuals experience by having their conditions belittled further exacerbates health inequities for people with disabilities. We encourage the inclusion of this example in the final rule.

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[14] Justice in Aging, Issue Brief: Why Too Many Psychotropic Medications in Nursing Facilities? (Jan. 17, 2023)
[15] Yorkston et al., Communicating about the experience of Pain and Fatigue in Disability, Quality of Life Research (Mar. 2010); Wang & Jacobs, From Awareness to Action: Pathways to Equity in Pain Management, *Health Equity* (Aug. 23, 2023).

Professional judgment in treatment (§ 84.56(c)(1))

We recommend defining what it means for a person to be "qualified" (or not qualified) for treatment. Providers' bias can seep into whether they determine an individual as qualifying for treatment. We recommend including that qualifications for treatment should be assessed with reasonable accommodations. We also encourage additional guidance around best practices to prevent discriminatory judgements. Such practices should include training and education around implicit bias (disability as well as age), disability accommodations, and healthcare access for intersectional identities.

Consent (§ 84.56(c)(2))

Justice in Aging strongly supports inclusion of this provision. Consent is a fundamental civil rights concept and is key to person-centered care and its importance cannot be overstated. Justice in Aging has described how informed consent is overlooked as a means to addressing inappropriate prescribing of antipsychotics in nursing facilities.[16]

Providing information (§ 84.56(c)(3))

We recommend revising the language that providers are not precluded from providing people with disabilities or their authorized representatives with information on different treatment options. Informed consent requires provider to inform individuals and authorized representatives of their various treatment options and associated risks and side effects.[17] Further, failure to disclose all treatment options effectively steers patients into a particular course, violating OCR guidance prohibiting Crisis Standards of Care plans from steering individuals away from life-sustaining treatments.[18] Limiting treatment information minimizes the autonomy of people with disabilities. Therefore, we recommend removing the "nothing in this section precludes" language in § 84.56(c)(3) and instead affirmatively require providers to inform individuals of the implications of all treatment options.

Additional Questions on Medical Treatment

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

We endorse the comments from the Consortium for Constituents with Disabilities (CCD). In addition to CCD's comments, we reiterate our advocacy for inclusive policies that support the increasing number of older adults with disabilities in the final rule. As previously stated, policies like age-based tiebreakers in Crisis Standards of Care allow for ableist judgments to prevent older adults with disabilities from receiving life-saving care. We strongly urge HHS to recognize the diversity of the disability community, and ensure policies in the final rule protect all the intersectional identities within the community.

General prohibitions against discrimination (§ 84.68(a))

Justice in Aging urges HHS to include language in the final regulations to clarify that "solely on the basis of disability" does not exclude the forms of discrimination delineated in the final rule or discrimination that results from thoughtlessness, indifference, and benign neglect, practices that have the effect of discrimination, and unintentional disparate-impact discrimination. As discussed in the CCD comment letter, this clarification and further discussion in the preamble would reflect case law and statutory intent, and be consistent with the U.S. Department of Justice's (DOJ) position in *CVS v. Doe.*

[16] *Supra* note 14.
[17] AMA, Code of Medical Ethics, Opinion 1.1.1 Informed Consent.
[18] *Supra* note 7.

Integration (§84.76)

Justice in Aging strongly supports HHS's aim to make the section 504 regulations consistent with *Olmstead* case law as well as DOJ's interpretation of the integration mandate under the ADA. We appreciate the additional specificity and examples to put covered entities on notice of their obligations to serve people with disabilities of all ages in the most integrated setting appropriate to their needs. As HHS points out in the NPRM, the integration mandate applies to all types of disabilities, including older adults with disabilities. In the preamble to the final rule, we urge HHS to re-emphasize this and discuss how the integration mandate applies to older adults and people currently residing in institutional settings. We recommend HHS include an example of an older adult to illustrate that older adults who meet the definition of a person with a disability must be afforded these protections.

We propose the following additional recommendations to further strengthen this section.

Application (§ 84.76(a))

We support the proposed clarification that the integration mandate applies to programs or activities that receive federal financial assistance and to recipients that operate such programs and activities. However, we strongly urge HHS to explicitly discuss this broad application to programs and activities beyond Medicaid. Specifically, we recommend the preamble to the final rule include examples of how the integration mandate applies to entities receiving Medicare funding, including Medicare Advantage plans, long-term care facilities, hospitals, and physicians. Older adults with disabilities are most likely to encounter discrimination in Medicare that impacts their ability to live in an integrated setting. For example, Medicare's discriminatory "in the home" restrictions on durable medical equipment may deny an individual access to the most integrated setting. We also recommend HHS discuss this rule's application to Older Americans Act programs and aging and disability network providers, including non-healthcare programs and services.

In the preamble, HHS briefly discusses how this NPRM relates to the proposed integration mandate in the 2022 NPRM on ACA Section 1557. HHS states that "The obligations in this proposed provision include many that are also articulated in Section 1557, but also extend to a broader range of programs and activities by recipients of Federal financial assistance." However, this statement about scope of applicability seems to be at odds with the preceding sentence: "The proposed integration provision in this [504] rule does not relate to benefit design or other health insurance coverage issues."

This distinction between the jurisdiction of 1557 and 504 seems unnecessary and potentially problematic. As Section 504 is the broader statute and Section 1557 incorporates Section 504, we believe these 504 rules should articulate both the integration mandate's application to what is covered in 1557, as well as a broader range of programs and activities. Problems could arise in enforcing the integration mandate if, for example, an individual who experienced discrimination based on benefit design or some other aspect of their insurance sued under Section 504 and not Section 1557. Further, this distinction could be confusing for covered entities such as Medicare Advantage plans, Medicaid managed care organizations, and long-term care facilities that are covered under both sets of regulations.

Discriminatory Action Prohibited (§84.76(b))

We support the proposed wording of this section describing covered entities' obligation to administer its programs and activities in the most integrated setting appropriate to the needs of the individual and prohibiting unnecessary segregation. We urge HHS to include robust discussion and examples in the preamble to the final rule. In particular, we recommend HHS reiterate that the failure to make reasonable modifications to policies, practices, or procedures, as required in proposed § 84.68(b)(7)

constitutes discrimination under this section. In addition, HHS should explain that this rule prohibits covered entities from denying services to an individual based on not being able to meet their needs when a reasonable accommodation would enable those needs to be met.

We also recommend a thorough discussion of the entity's obligation to provide individuals with meaningful, informed choice to live in the most integrated setting. As the vast majority of people with disabilities, including older adults, prefer to live in integrated settings, this should be the presumption. Entities should be prohibited from assuming an individual opposes an integrated setting without that individual's informed and explicit choice after addressing any history of institutionalization or other effects of segregation. The setting options themselves, as well as the process of informing and making choices, must accommodate the individual's disability, meet their language access needs, and be culturally appropriate.

Definition of Most Integrated Setting (§84.10)

We support making the definition of most integrated setting consistent with DOJ guidance and other definitions. However, we recommend more discussion and emphasis in the final rule on autonomy and other aspects of the definition beyond interactions with non-disabled people.

Definition of Segregated Setting (§84.76(c))

We agree with HHS's assessment that the types of restrictions listed in the proposed definition limit the opportunity for people with disabilities to interact as members of the community with nondisabled individuals. We recommend mirroring the DOJ guidance's language clarifying that the characteristics listed in the definition are examples, and not an exhaustive list, by using "include, but not limited to" language.

We appreciate that "lack of autonomy" is included in the proposed definition as a type of restriction that characterizes a segregated setting. However, we recommend greater discussion of this critical concept in the preamble to the final rule and suggest using "lack of choice" in the regulatory text to make this concept more understandable.

Specific Prohibitions (§84.76(d))

Justice in Aging strongly supports including all of the proposed specific prohibitions in the final regulatory text. With respect to (d)(4), we support using "serious risk of institutionalization" as the standard and the proposed regulatory text that, "Individuals with disabilities need not wait until the harm of institutionalization or segregation occurs to assert their right to avoid unnecessary institutionalization." This proposed provision is consistent with DOJ guidance and the vast majority of case law.

Fundamental Alteration (§84.76(e))

We support the proposed regulatory text and appreciate HHS's discussion of the types of modifications that do not constitute a fundamental alteration under Medicaid. We recommend HHS reiterate and further clarify in the preamble to the final rule that increasing the cap of a 1915(c) waiver program does not in and of itself constitute a fundamental alteration. We further recommend HHS state in the preamble that providing a new service (including a new Medicaid service) is not a fundamental alteration if it is a service they are required to be providing but have failed to do so, or is a service they are already providing to another population. We also support HHS's statement in the preamble that "Recipients cannot avoid their obligations under section 504 and *Olmstead* by characterizing as a 'new

service' those services that they currently or plan to in the future offer only in institutional settings." We recommend including this in the final rule's discussion of §84.76(e) as well.

Integration Question 2: We seek comment on what may constitute a fundamental alteration for recipients who are not public entities, for example, an individual skilled nursing facility responsible for identifying and preparing individual who can and want to be discharged to available community-based services.

While creating "entirely new services" that an entity is not otherwise required to provide may be a fundamental alteration for non-public entities, it is certainly not a fundamental alteration, nor even a modification, for nursing facilities to engage in discharge planning or provide services to prepare individuals for discharge. Nursing facilities are currently required to engage in "comprehensive person-centered care planning" under federal regulations, including the requirement to "develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions."[19] We recommend HHS clarify that a covered entity's compliance with care planning obligations under other laws does not exempt its discharge planning from scrutiny under Section 504. HHS should also provide examples of the types of supports a facility may be required to provide to comply with its Section 504 obligations to facilitate transition to the community beyond what federal regulations already mandate. For example, a facility may need to secure additional personnel to assist with transitions and better coordinate with legal aid and other community-based services to help with housing.

Civil Rights Obligations as Distinct from Medicaid Law and Regulations

We strongly support HHS's position that covered entities' civil rights obligations under Section 504 apply independently of Medicaid, Medicare, and other laws and regulations. We believe that a strong 504 rule clarifying what the integration mandate requires will be a tool not only for enforcement but for proactive Medicaid and Medicare policy that promotes community integration for people with disabilities of all ages. For example, while this rule does not require the Centers for Medicare and Medicaid Services (CMS) to assess compliance with 504 when approving Medicaid waivers, CMS could certainly incorporate the integration and other nondiscrimination principles articulated in the final rule into its review of such waivers. Such an approach would further HHS's commitment to advancing equity.

Accessible Medical Equipment (§§ 84.90-84.94)

Justice in Aging strongly supports codifying standards for accessible medical diagnostic equipment to make them enforceable. Accessible medical equipment is essential to prevention, diagnosis and treatment and the benefit extends well beyond the disability community. Older adults in particular will benefit even if they do not identify as disabled or meet the definition of disability.

Because everyone, including people without disabilities, can use accessible medical equipment we strongly urge HHS to revise the requirements to ensure that overtime, all medical equipment will be accessible. As people with disabilities need to access every type of care and live in every community, there should not be distinctions by provider, clinic, or specialty. Achieving universal accessibility is particularly critical for people with other marginalized identities. For example, a queer individual with a disability should not be forced to see a provider that they do not feel safe with as a queer person simply because that is the only provider with the necessary accessible medical equipment.

[19] 42 CFR § 483.21(c); *see also* F-Tag F660 of Appendix PP of State Operations Manual.

We also recommend expanding these standards beyond diagnostic equipment to ensure that treatment (e.g., dialysis, radiation therapy, surgery, oral health care), as well as rehabilitation and habilitation, are also accessible. Finally, making medical equipment accessible to people with non-mobility disabilities is equally critical. For example, in our advocacy to address oral health inequities for people with disabilities, we have highlighted the need to address communication access, mental and emotional access, as well as physical access.[20]

Conclusion

Thank you for the opportunity to comment. Justice in Aging urges HHS to finalize this rule as soon as possible. If any questions arise concerning this submission, please contact Natalie Kean, Director of Federal Health Advocacy, at nkean@justiceinaging.org.

Sincerely,

Amber Christ
Managing Director of Health Advocacy

[20] Justice in Aging, Adding a Dental Benefit to Medicare: Addressing Oral Health Inequity Based on Disability (2020); The Independence Center, Creating Disability-Friendly Dental Practices, (Jul. 2019).