

paragraph (f)(6)(i) is corrected to read, “(f)(4) of this section to be treated as a”.

■ 8. On page 82221, the second column, eleventh line of paragraph (f)(6)(ii) is corrected to read, “any successor form(s), filed with its timely”.

■ 9. On page 82222, the first column, the seventh line from the bottom of paragraph (g)(3)(ii) is corrected to read, “property. Paragraphs (g)(3)(ii)(A) and (B)”.

■ 10. On page 82222, the first column, the third line of paragraph (g)(3)(ii)(A) is corrected to read, “generating energy property, use the”.

#### § 1.6418–5 [Corrected]

■ 11. On page 82223, the second column, paragraph (f)(1), the fourth line from the bottom of the column is corrected to read, “described in § 1.48–13(c)(5)), such”.

■ 12. On page 82223, the third column, the last line of paragraph (f)(2) is corrected to read, “defined in § 1.48–13(c)(4).”.

■ 13. On page 82223, the third column, the last line of paragraph (f)(3) is corrected to read, “13(c)(3)(ii).”.

**Oluwafunmilayo A. Taylor,**

*Section Chief, Publications and Regulations Section, Associate Chief Counsel, (Procedure and Administration).*

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## DEPARTMENT OF JUSTICE

### 28 CFR Part 35

[Docket Number CRT 143 AG Order No. 5852–2024]

RIN 1190–AA78

### Nondiscrimination on the Basis of Disability; Accessibility of Medical Diagnostic Equipment of State and Local Government Entities

**AGENCY:** Civil Rights Division, Department of Justice.

**ACTION:** Notice of proposed rulemaking.

**SUMMARY:** The Department of Justice (“Department”) is proposing to revise the regulations implementing title II of the Americans with Disabilities Act (“ADA”) to establish specific requirements, including the adoption of specific technical standards and scoping requirements, for making accessible to the public the services, programs, and activities offered by State and local governments through their Medical Diagnostic Equipment (“MDE”).

**DATES:** All comments must be submitted on or before February 12, 2024. Commenters should be aware that the

electronic Federal Docket Management System (“FDMS”) will accept comments submitted prior to midnight Eastern Time on the last day of the comment period. Comments received after the close of the comment period are highly disfavored and will be marked “late.” The Department is not required to consider late comments.

**ADDRESSES:** You may submit comments, identified by RIN 1190–AA78, by any one of the following methods:

- **Federal eRulemaking website:** <https://www.regulations.gov>. Follow the website’s instructions for submitting comments.

- **Overnight, courier, or hand delivery:** Disability Rights Section, Civil Rights Division, U.S. Department of Justice, 150 M St. NE, 9th Floor, Washington, DC 20002.

**FOR FURTHER INFORMATION CONTACT:** Rebecca B. Bond, Chief, Disability Rights Section, Civil Rights Division, U.S. Department of Justice, at (202) 307–0663 (voice or TTY). This is not a toll-free number. Information may also be obtained from the Department’s toll-free ADA Information Line at (800) 514–0301 (voice) or (833) 610–1264 (TTY). You may obtain copies of this notice of proposed rulemaking (“NPRM”) in an alternative format by calling the ADA Information Line at (800) 514–0301 (voice) or (833) 610–1264 (TTY). A link to this NPRM is also available on <https://www.ada.gov>.

### Electronic Submission of Comments and Posting of Public Comments

Interested persons are invited to participate in this rulemaking by submitting written comments on all aspects of this rule via one of the methods and by the deadline stated above. When submitting comments, please include “RIN 1190–AA78” in the subject field. The Department also invites comments that relate to the economic, environmental, or federalism effects that might result from this rule. Comments that will provide the most assistance to the Department in developing this rule will reference a specific portion of the rule or respond to a specific question, explain the reason for any recommended change, and include data, information, or authority that support such recommended change.

Please note that all comments received are considered part of the public record and made available for public inspection at <https://www.regulations.gov>. Such information includes personally identifiable information (“PII”) (such as your name and address). Interested persons are not

required to submit their PII in order to comment on this rule. However, any PII that is submitted is subject to being posted to the publicly accessible <https://www.regulations.gov> site without redaction.

Confidential business information clearly identified as such in the first paragraph of the comment will not be placed in the public docket file.

The Department may withhold from public viewing information provided in comments that it determines may impact the privacy of an individual or is offensive. For additional information, please read the Privacy Act notice that is available via the link in the footer of <https://www.regulations.gov>. To inspect the agency’s public docket file in person, you must make an appointment with the agency. Please see the **FOR FURTHER INFORMATION CONTACT** paragraph above for agency contact information.

### SUPPLEMENTARY INFORMATION

#### I. Executive Summary

In this NPRM, the Department is proposing to revise its title II ADA regulations, 28 CFR part 35, to adopt the standards for accessible MDE issued by the Architectural and Transportation Barriers Compliance Board (“Access Board”), 36 CFR part 1195, app. (“MDE Standards”). The Access Board issued the MDE Standards under section 510 of the Rehabilitation Act, 29 U.S.C. 794f. The Department is proposing to adopt specific technical standards and scoping requirements under the ADA to ensure that MDE used by public entities to offer services, programs, and activities at places such as hospitals and other health care facilities is accessible to individuals with disabilities. MDE includes things like medical examination tables, weight scales, dental chairs, and radiological diagnostic equipment. Without accessible MDE, individuals with disabilities may not be afforded an equal opportunity to receive medical care, including routine examinations, which could have serious implications for their health. A lack of accessible MDE may also undermine the quality of care received by individuals with disabilities, “leading to delayed and incomplete care, missed diagnoses, exacerbation of the original disability, and increases in the likelihood of the development of secondary conditions.”<sup>1</sup> For instance, patients

<sup>1</sup> Nat’l Council on Disability, *Enforceable Accessible Medical Equipment Standards: A Necessary Means to Address the Health Care Needs of People with Mobility Disabilities* 7 (May 20,

Continued

with disabilities have had to forgo Pap smears because they could not safely transfer from their wheelchairs to a fixed-height exam table.<sup>2</sup> Similarly, inaccessible mammography machines have contributed to low breast cancer screening rates for patients with disabilities.<sup>3</sup>

Section 510 requires the Access Board to promulgate regulatory standards setting forth minimum technical criteria for MDE used in physicians' offices, clinics, emergency rooms, hospitals, and other medical settings.<sup>4</sup> Under the statute, the standards must ensure that such equipment is accessible to, and usable by, individuals with accessibility needs, which include people with disabilities, and must allow independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible. Section 510 does not give the Access Board authority to enforce these standards.<sup>5</sup> Compliance with the standards is mandatory only if an enforcing authority adopts the standards as mandatory for entities subject to its jurisdiction.<sup>6</sup> In this NPRM, the Department proposes to adopt the MDE Standards under title II of the ADA.

## II. Background

### A. Statutory and Rulemaking Overview

Title II of the ADA protects qualified persons with disabilities from discrimination on the basis of disability in services, programs, and activities provided by State and local government entities. 42 U.S.C. 12132.

The ADA authorizes the Attorney General to promulgate regulations to carry out the provisions of title II, with the exception of certain discrete transportation provisions.<sup>7</sup> The ADA also authorizes the Attorney General to promulgate regulations to carry out the provisions of title III, which focuses on public accommodations.<sup>8</sup> In 1991, the Department issued its final rules implementing titles II and III, which were codified at 28 CFR part 35 (title II)

and part 36 (title III) and adopted the ADA Standards for Accessible Design.<sup>9</sup>

In 2004, the Department published an advance notice of proposed rulemaking ("2004 ANPRM") to begin the process of updating the 1991 regulations and to adopt revised ADA Standards based on the relevant parts of the Access Board's 2004 ADA/Architectural Barriers Act Accessibility Guidelines ("2004 ADA/ABA Guidelines").<sup>10</sup> The 2004 ANPRM asked for public comment on a range of issues not specifically addressed in the ADA regulations, including coverage of movable or portable equipment and furniture.<sup>11</sup> The Department subsequently issued an NPRM in 2008.<sup>12</sup> Although public comments in response to the ANPRM had supported the promulgation of specific accessibility standards for equipment and furniture, the Department's 2008 NPRM announced its decision not to address equipment and furniture at that time.<sup>13</sup> Instead, the Department continued its approach of requiring covered entities to provide accessible equipment and furniture as needed to comply with the ADA's general nondiscrimination requirements under the Department's existing regulations.

On July 26, 2010, the Department announced its plan to issue final rules updating its title II and III regulations and adopting standards consistent with 2004 ADA/ABA Guidelines and the requirements contained in 28 CFR 35.151, naming them the 2010 ADA Standards for Accessible Design ("2010 ADA Standards").<sup>14</sup> On that same day, the Department issued an ANPRM to consider possible changes to requirements under the ADA to ensure that equipment and furniture, including MDE, used in services, programs, and activities provided by State and local governments and public accommodations, are accessible to people with disabilities.<sup>15</sup> The Department subsequently bifurcated the rulemaking considered in the 2010 ANPRM with the intent to address the accessibility requirements for MDE in a

separate rulemaking.<sup>16</sup> However, in December 2017, the Department withdrew the 2010 ANPRM to reevaluate whether the imposition of specific regulatory standards for the accessibility of non-fixed equipment and furniture was necessary and appropriate.<sup>17</sup>

In 2021, the Department indicated its plan to issue an ANPRM on possible revisions to its ADA regulations to ensure the accessibility of equipment and furniture in public entities' and public accommodations' programs and services.<sup>18</sup> Subsequently, in 2022, the Department decided to bifurcate this rulemaking and announced that it planned to publish a separate ANPRM that solely addresses the accessibility of MDE under both title II and title III.<sup>19</sup> The Department has since decided to proceed with its MDE rulemaking under title II through an NPRM, rather than first issuing an ANPRM. The Department has received complaints indicating that more specific technical guidance would help give covered entities and individuals with disabilities more clarity about existing obligations and rights concerning the accessibility of MDE under title II.

The Department is coordinating its publication of this proposed rule with the Department of Health and Human Services ("HHS"), which issued an NPRM under section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794, that addresses the accessibility of MDE for recipients of Federal financial assistance.<sup>20</sup> Title II is modeled on

<sup>16</sup> See, Off. of Mgmt. & Budget, Off. of Info. and Regul. Affs., *Unified Agenda of Federal Regulatory and Deregulatory Actions* (Fall 2011), <https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201110&RIN=1190-AA66> [<https://perma.cc/D6TE-RUHR>].

<sup>17</sup> 82 FR 60932 (Dec. 26, 2017).

<sup>18</sup> See Off. of Mgmt. & Budget, Off. of Info. and Regul. Affs., *Unified Agenda of Federal Regulatory and Deregulatory Actions* (Fall 2021), <https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202110&RIN=1190-AA76> [<https://perma.cc/D6TE-RUHR>].

<sup>19</sup> See Off. of Mgmt. & Budget, Off. of Info. and Regul. Affs., *Unified Agenda of Federal Regulatory and Deregulatory Actions* (Spring 2022), <https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202204&RIN=1190-AA78> [<https://perma.cc/8BJ3-RYYY>] (explaining that "[t]he Department previously announced that it intends to issue an ANPRM, titled Nondiscrimination on the Basis of Disability by State and Local Governments and Places of Public Accommodation; Equipment and Furniture (RIN 1190-AA76) addressing possible revisions to its ADA regulations to ensure the accessibility of equipment and furniture generally. However, the Department has decided to publish a separate ANPRM that solely addresses the accessibility of medical diagnostic equipment (MDE) under titles II and III of the ADA, given the specialized nature of MDE.").

<sup>20</sup> 88 FR 63392 (Sept. 14, 2023).

2021), [https://ncd.gov/sites/default/files/Documents/NCD\\_Medical\\_Equipment\\_Report\\_508.pdf](https://ncd.gov/sites/default/files/Documents/NCD_Medical_Equipment_Report_508.pdf) ("NCD Report") [<https://perma.cc/6W4U-TVEX>].

<sup>2</sup> See *id.* at 17.

<sup>3</sup> See *id.* at 18.

<sup>4</sup> 29 U.S.C. 794f(a).

<sup>5</sup> See *id.* at 794f.

<sup>6</sup> See 36 CFR 1195.1 ("Other agencies, referred to as an enforcing authority in the standards, may adopt the standards as mandatory requirements for entities subject to their jurisdiction."); 36 CFR pt. 1195, app., sec. M102.1 (stating that enforcing authorities may include the Department of Justice).

<sup>7</sup> 42 U.S.C. 12134.

<sup>8</sup> *Id.* 12186(b).

<sup>9</sup> 56 FR 35694 (July 26, 1991); 56 FR 35544 (July 26, 1991).

<sup>10</sup> 69 FR 58768 (Sept. 30, 2004); see also 69 FR 44084 (July 23, 2004).

<sup>11</sup> 69 FR at 58774–75.

<sup>12</sup> 73 FR 34466 (June 17, 2008).

<sup>13</sup> *Id.* at 34474–75.

<sup>14</sup> See U.S. Dep't of Just., *Justice Department's 2010 ADA Standards for Accessible Design Go into Effect* (Mar. 15, 2012), <https://www.justice.gov/opa/pr/justice-department-s-2010-ada-standards-accessible-design-go-effect> [<https://perma.cc/52UB-WRR4>]. These final rules were published on September 15, 2010. See 75 FR 56164 (Sept. 15, 2010); 75 FR 56236 (Sept. 15, 2010).

<sup>15</sup> 75 FR 43452 (July 26, 2010).

section 504,<sup>21</sup> and title II and section 504 are generally understood to impose similar requirements, given the similar language employed in the ADA and the Rehabilitation Act.<sup>22</sup> The legislative history of the ADA makes clear that title II was intended to extend the requirements of section 504 to apply to all State and local governments, regardless of whether they receive Federal funding, demonstrating Congress's intent that title II and section 504 be interpreted consistently.<sup>23</sup>

The legislative history of the Rehabilitation Act Amendments of 1992<sup>24</sup> states that the revisions to the Rehabilitation Act's findings, purpose, and policy provisions are "a reaffirmation of the precepts of the Americans with Disabilities Act,"<sup>25</sup> and that these principles are intended to guide the Rehabilitation Act's policies, practices, and procedures.<sup>26</sup> Further, courts interpret the ADA and section 504 consistently.<sup>27</sup> Thus, the Department believes there is and should be parity between the relevant provisions of title II and section 504.

Given the relationship between title II and section 504 and congressional intent that the two disability rights laws be interpreted consistently, both Departments are proceeding with rulemakings that provide the same requirements, one for public entities subject to title II of the ADA and the other for recipients of Federal financial assistance from HHS.

The Department will continue to consider the remaining issues concerning MDE under title III as well as equipment and furniture under both titles, although those issues are not the subjects of rulemaking at this time.

#### *B. Legal Foundation for Accessible MDE*

This NPRM applies to health care services, programs, and activities that public entities offer through or with the use of MDE. Title II of the ADA prohibits discrimination on the basis of disability in all services, programs, and activities offered by public entities.<sup>28</sup> Through this mandate and the Department's implementing regulations, the ADA requires public entities to provide accessible equipment and

furniture as necessary to comply with title II's reasonable modification, effective communication, and program accessibility requirements. However, the Department has never adopted specific technical standards that address what constitutes accessible MDE.

Under title II, public entities must provide reasonable modifications when necessary to avoid discrimination on the basis of disability unless those modifications would fundamentally alter the nature of the public entity's service, program, or activity.<sup>29</sup> Title II entities also must ensure that communications with individuals with disabilities are as effective as communications with others, including through the provision of appropriate auxiliary aids and services.<sup>30</sup> These auxiliary aids include the "[a]cquisition or modification of equipment or devices."<sup>31</sup>

Under the program accessibility requirement of title II, no qualified individual with a disability shall, because a public entity's facilities are inaccessible to or unusable by individuals with disabilities, 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.<sup>32</sup> A public entity must operate each service, program, or activity so that, when viewed in its entirety, the service, program, or activity is readily accessible to and usable by persons with disabilities, subject to a defense of fundamental alteration or undue burden.<sup>33</sup> A public entity may comply with the program accessibility requirement through such means as redesign or acquisition of equipment.<sup>34</sup>

#### *C. Overview of Access Board's MDE Standards*

In implementing the mandate set forth in section 510 of the Rehabilitation Act to promulgate technical standards for accessible MDE, the Access Board received input from various stakeholders through a multi-year deliberative process and published the MDE Standards on January 9, 2017.<sup>35</sup> The Access Board divides the MDE Standards into four separate technical criteria based on how the equipment is used by the patient: (1) supine, prone,

or side-lying position; (2) seated position; (3) seated in a wheelchair; and (4) standing position.<sup>36</sup> For each category of use, the MDE Standards provide for independent entry to, use of, and exit from the equipment by patients with disabilities to the maximum extent possible.

The technical requirements for MDE used by patients in the supine, prone, or side-lying position (such as examination tables) and MDE used by patients in the seated position (such as examination chairs) focus on ensuring that the patient can transfer from a mobility device onto the MDE.<sup>37</sup> The other two categories set forth the necessary technical requirements to allow the patient to use the MDE while seated in their wheelchair (such as during a mammogram) or while standing (such as on a weight scale), respectively.<sup>38</sup> The MDE Standards also include technical criteria for supports, including for transfer, standing, leg, head, and back supports; instructions or other information communicated to patients through the equipment; and operable parts used by patients.<sup>39</sup>

The Access Board's MDE Standards currently contain a temporary standard governing the minimum low height requirement for transfers from diagnostic equipment used by patients in a supine, prone, side-lying, or seated position.<sup>40</sup> Specifically, the temporary standard provides for a minimum low transfer height requirement of 17 inches to 19 inches. The temporary nature of this standard was due to insufficient data on the extent to which, and how many, individuals would benefit from a transfer height lower than 19 inches. While this temporary standard is in effect, any low transfer height between 17 and 19 inches will meet the MDE Standards. Under a sunset provision, as extended, this low height range remains in effect only until January 10, 2025.<sup>41</sup>

On May 23, 2023, the Access Board issued an NPRM that proposes removing the sunset provisions in the Board's existing MDE Standards related to the low height specifications for transfer surfaces, and replacing them with final specifications for the low transfer height of medical diagnostic equipment used in the supine, prone, side-lying, and seated positions.<sup>42</sup> Following an extension, the comment period for that

<sup>21</sup> See, e.g., H.R. Rep. No. 101-485(II), at 84 (1990).

<sup>22</sup> See, e.g., 42 U.S.C. 12201(a).

<sup>23</sup> See H. Rep. No. 101-485(II), at 84 (1990).

<sup>24</sup> Public Law 102-569 (1992).

<sup>25</sup> S. Rep. No. 102-357, at 14 (1992).

<sup>26</sup> See *id.*; see also H.R. Rep. No. 102-822, at 81 (1992).

<sup>27</sup> See, e.g., *Smith v. Harris Cnty.*, 956 F.3d 311, 317 (5th Cir. 2020); *K.M. ex rel. Bright v. Tustin Unified Sch. Dist.*, 725 F.3d 1088, 1098 (9th Cir. 2013).

<sup>28</sup> 42 U.S.C. 12132.

<sup>29</sup> 28 CFR 35.130(b)(7)(i).

<sup>30</sup> See 28 CFR 35.160.

<sup>31</sup> 28 CFR 35.104; see also 36 CFR pt. 1195, app., sec. M306.1 (setting forth technical standards for MDE that communicates instructions or other information to the patient).

<sup>32</sup> *Id.* 35.149.

<sup>33</sup> *Id.* 35.150(a).

<sup>34</sup> *Id.* 35.150(b)(1).

<sup>35</sup> 82 FR 2810 (Jan. 9, 2017).

<sup>36</sup> 36 CFR pt. 1195, app., sec. M301-04.

<sup>37</sup> See *id.* sec. M301-02.

<sup>38</sup> See *id.* sec. M303-04.

<sup>39</sup> See *id.* sec. M305-07.

<sup>40</sup> See *id.* sec. M301.2.1, 302.2.1.

<sup>41</sup> See *id.* sec. M301.2.2, 302.2.2; 87 FR 6037 (Feb. 3, 2022).

<sup>42</sup> 88 FR 33056 (May 23, 2023).

NPRM closed on August 31, 2023.<sup>43</sup> After the Access Board analyzes the comments that it receives, the Board will issue a final, updated minimum low transfer height standard. After this new standard is adopted, the Department will consider issuing a supplemental rulemaking under title II proposing to adopt the updated standards.

#### *D. Need for the Adoption of MDE Standards*

The accessibility of MDE is essential to providing equal access to medical care to people with disabilities. In developing this proposed subpart, the Department considered the well-documented barriers that individuals with disabilities face when accessing MDE, as well as the benefits for people with disabilities and health care workers alike of using accessible MDE.<sup>44</sup> The accessibility or inaccessibility of MDE impacts a substantial population—according to an estimate by the Centers for Disease Control and Prevention, approximately 61 million adults live with a disability in the U.S., and 13.7 percent of those individuals have a mobility disability with serious difficulty walking or climbing stairs.<sup>45</sup> According to a 2022 estimate by the U.S. Census Bureau, over 44 million people with disabilities live outside of institutional settings in the United States, and the most common category of disability is mobility or ambulatory impairment.<sup>46</sup>

While not all individuals with a mobility disability with serious difficulty walking or climbing stairs or individuals with mobility or ambulatory impairments will require accessible MDE, or benefit from it to the same extent, significant portions of these populations will benefit from accessible MDE. Further, a number of studies and

reports have shown that individuals with disabilities may be less likely to get routine or preventative medical care than people without disabilities because of barriers to accessing appropriate care through MDE.<sup>47</sup> In one case, a patient with a disability remained in his wheelchair for the entirety of his annual physical exam, which consisted of his doctor listening to his heart and lungs underneath his clothing, looking inside his ears and throat, and then stating, “I assume everything below the waist is fine.”<sup>48</sup> In another case, a patient with a disability could be transferred to a standard exam table, but extra staff was needed to keep her from falling off the table since it did not have any side rails. As a result of this and a number of other frightening experiences, the patient avoided going to the doctor unless she was very ill.<sup>49</sup> Multiple studies have found that individuals with certain disabilities face barriers to accessing MDE and are often denied accessible MDE by their health care providers.<sup>50</sup> Accessible MDE is thus often critical to a public entity’s ability to provide a person with a disability equal access to, and opportunities to benefit from, its health care services, programs, and activities.

In the over 30 years since the ADA was enacted, the Department, in implementing and enforcing the ADA, has gained a better understanding of the ongoing barriers posed by inaccessible MDE and the solutions provided by accessible MDE. The Department has received numerous complaints from patients with disabilities whose health care providers have forgone the most basic of care—from performing a full body examination to obtaining an accurate weight before administering anesthesia—because of the lack of accessible MDE. In recognition of the importance of accessible health care, the

Department launched the Barrier-Free Health Care Initiative, which, among other goals, sought to advance physical access to medical care for people with disabilities. As part of this initiative, the Department has entered into numerous settlement agreements with health care providers that have required the providers to purchase accessible MDE, including patient lifts and examination and treatment equipment, for their facilities.<sup>51</sup> These settlement agreements, and a description of the Barrier-Free Health Care Initiative, are available to the public at <https://www.ada.gov/barrierfreehealthcare.htm> [<https://perma.cc/9TT7-BCRN>].

The Department has also consistently provided information to covered entities on how they can make their health care services, programs, and activities accessible to individuals with mobility disabilities. For example, the Department and the Department of Health and Human Services jointly issued a technical assistance document on medical care for people with mobility disabilities, addressing how accessible MDE can be critical to ensure that people with disabilities receive medical services equal to those received by people without disabilities.<sup>52</sup> In particular, the document explains that the “[a]vailability of accessible medical equipment is an important part of providing accessible medical care, and doctors and other providers must ensure that medical equipment is not a barrier to individuals with disabilities.”<sup>53</sup> The guidance also provides examples of accessible medical equipment, including adjustable-height exam tables and chairs, wheelchair-accessible scales, adjustable-height radiologic equipment, portable floor and overhead track lifts, gurneys, and stretchers, and it discusses how people with mobility disabilities use this equipment.

The Department recognizes that in addition to its efforts to enforce and provide technical assistance on the ADA to ensure that people with disabilities have equal access to medical care, providing enforceable technical standards will help ensure clarity to

<sup>43</sup> 88 FR 50096 (Aug. 1, 2023).

<sup>44</sup> Nat’l Council on Disability, *The Current State of Health Care for People with Disabilities* (Sept. 30, 2009), <https://files.eric.ed.gov/fulltext/ED507726.pdf> [<https://perma.cc/5FR5-DZU6>]; see, e.g., Dep’t of Health & Human Servs., Administration for Community Living, *Wheelchair-Accessible Medical Diagnostic Equipment: Cutting Edge Technology, Cost-Effective for Health Care Providers, and Consumer-Friendly* (July 26, 2019), <https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/MDE%20Fact%20Sheet%20Final.docx> [<https://perma.cc/GW83-62WW>].

<sup>45</sup> U.S. Dep’t of Health & Human Servs., Ctrs. for Disease Control & Prevention, *Disability Impacts All of Us*, [https://www.cdc.gov/ncbddd/disabilityandhealth/documents/disabilities\\_impacts\\_all\\_of\\_us.pdf](https://www.cdc.gov/ncbddd/disabilityandhealth/documents/disabilities_impacts_all_of_us.pdf) [<https://perma.cc/AX9E-9WU3>].

<sup>46</sup> U.S. Census Bureau, American Community Survey, *Disability Characteristics*, <https://data.census.gov/cedsci/table?t=Disability&tid=ACST1Y2019.S1810> [<https://perma.cc/KX82-VMYD>].

<sup>47</sup> See, e.g., Anna Marrocco & Helene J. Krouse, *Obstacles to Preventive Care for Individuals with Disability: Implications for Nurse Practitioners*, 29 J. Am. Ass’n of Nurse Pract. 282, 289 (May 2017); U.S. Dep’t of Health & Human Servs., Office of the Surgeon Gen., *The Surgeon General’s Call to Action to Improve the Health and Wellness of Persons with Disabilities* (2005), <https://www.ncbi.nlm.nih.gov/books/NBK44667/> [<https://perma.cc/77DZ-WRM9>]; NCD Report at 14.

<sup>48</sup> NCD Report at 15.

<sup>49</sup> *Id.* at 16–17.

<sup>50</sup> See Anne Ordway et al., *Health Care Access and the Americans with Disabilities Act: A Mixed Methods Study*, 14 Disability and Health J. 1, 2, 5 (2021) (stating that of 562 people with disabilities surveyed, 27 percent had difficulty accessing exam tables); see also Jennifer L. Wong et al., *Identification of Targets for Improving Access to Care in Persons with Long Term Physical Disabilities*, 12 Disability and Health J. 366, 369 (2019) (stating that of the 462 people who needed a height-adjustable examination table, 56 percent received it).

<sup>51</sup> See, e.g., Settlement Agreement between the United States and Charlotte Radiology, P.A. (Aug. 13, 2018), [https://archive.ada.gov/charlotte\\_radiology\\_sa.html](https://archive.ada.gov/charlotte_radiology_sa.html) [<https://perma.cc/ZC5W-LV3M>]; Settlement Agreement between the United States and Tufts Medical Center (Feb. 28, 2020), [https://archive.ada.gov/tufts\\_medical\\_ctr\\_sa.html](https://archive.ada.gov/tufts_medical_ctr_sa.html) [<https://perma.cc/YQG3-ZDZC>].

<sup>52</sup> See U.S. Dep’t of Just., Civ. Rts. Div., *Access to Medical Care for Individuals with Mobility Disabilities*, <https://www.ada.gov/resources/medical-care-mobility/> [<https://perma.cc/UH8Y-NZWL>] (June 26, 2020).

<sup>53</sup> *Id.*

public entities on how to fulfill their existing obligations under title II in their health care services, programs, and activities. The COVID-19 pandemic had a devastating and disproportionate impact on people with disabilities and underscored how dire the consequences may be for those who lack adequate access to medical care and treatment. As the National Council on Disability (NCD) Report on accessible medical equipment standards notes, significant health care disparities for persons with disabilities are due in part to the lack of physical access to MDE, and “[e]nsuring physical access to care through accessible MDE is necessary to equitably provide medical care for all people, and the need continues to grow.”<sup>54</sup> As a result of its findings, NCD called upon the Department to revise its ADA regulations to formally adopt the MDE Standards.<sup>55</sup>

Accordingly, the Department is proposing changes to its ADA regulations that can help ensure that vital health care services, programs, and activities are equally available to individuals with disabilities. Specifically, the Department is considering adopting and incorporating into its title II ADA regulations the specific technical requirements for accessible MDE that are set forth in the Access Board’s MDE Standards.

### III. Section-by-Section Analysis

This section details the Department’s proposed changes to the title II ADA regulations, including the reasoning behind the proposals, and poses questions for public comment.

#### § 35.104 Definitions

The Department proposes to revise 28 CFR 35.104 to add definitions for the terms “*medical diagnostic equipment*” and “*Standards for Accessible Medical Diagnostic Equipment*.”

#### Medical Diagnostic Equipment

The Department proposes that the term “*medical diagnostic equipment*” be defined consistently with the MDE Standards, as “[e]quipment used in, or in conjunction with, medical settings by health care providers for diagnostic purposes.” This definition includes the examples in 29 U.S.C. 794f, which states that the MDE Standards shall “set[] forth the minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physician’s offices, clinics, emergency rooms, hospitals, and other medical settings,” and “shall apply to equipment that

includes examination tables, examination chairs (including chairs used for eye examinations or procedures), and dental examinations or procedures), weight scales, mammography equipment, x-ray machines, and other radiological equipment commonly used for diagnostic purposes by health professionals.” These examples are illustrative of types of MDE but are not exhaustive.

#### Standards for Accessible Medical Diagnostic Equipment

The Department proposes that the term “*Standards for Accessible Medical Diagnostic Equipment*” means the standards at 36 CFR part 1195, promulgated by the Access Board under section 510 of the Rehabilitation Act of 1973, as amended, found in the Appendix to 36 CFR part 1195.

#### § 35.210 Requirements for Medical Diagnostic Equipment

This section provides general accessibility requirements for services, programs, and activities that public entities provide through or with the use of MDE. Public entities must ensure that their services, programs, and activities offered through or with the use of MDE are accessible to individuals with disabilities.

Under this general provision (barring an applicable limitation or defense), a public entity that provides health care cannot deny services that it would otherwise provide to a patient with a disability because the provider lacks accessible MDE. A health care provider also cannot require a patient with a disability to bring someone along with them to help during an exam. A patient may choose to bring another person such as a friend, family member, or personal care aide to an appointment, but regardless, the health care provider may need to provide reasonable assistance to enable the patient to receive medical care.<sup>56</sup> Such assistance may include helping a person who uses a wheelchair to transfer from their wheelchair to the exam table or diagnostic chair.<sup>57</sup> The health care provider cannot require the person accompanying the patient to assist.

#### § 35.211 Newly Purchased, Leased, or Otherwise Acquired Medical Diagnostic Equipment

For MDE that public entities purchase, lease, or otherwise acquire more than 60 days after the publication of the final rule in the **Federal Register**, the Department proposes to adopt an approach that draws on the approach that the existing title II regulations applied to new construction and alterations of buildings and facilities.<sup>58</sup> The Department would require that all MDE that a public entity purchases, leases, or otherwise acquires after the rule’s effective date must be accessible, unless and until the proposed rule’s scoping requirements, set forth in more detail in § 35.211(b), are satisfied.

• *Issue 1: The Department seeks public comment on whether 60 days would be an appropriate amount of time for these requirements, and, if 60 days would not be an appropriate amount of time, what the appropriate amount of time would be.*

As in the fixed or built-in environment, this rule is proposing that the accessibility of MDE will be governed by a specific set of design standards promulgated by the Access Board that sets forth technical requirements for accessibility. So long as a public entity has the amount of accessible MDE set forth in the scoping requirements in § 35.211(b), the public entity is not required to continue to obtain accessible MDE when it purchases, leases, or otherwise acquires MDE after the effective date. However, a public entity may choose to acquire additional accessible MDE after it satisfies the scoping requirements.

#### § 35.211(a) Requirements for Newly Purchased, Leased, or Otherwise Acquired Medical Diagnostic Equipment

Paragraph (a) would adopt the Access Board’s MDE Standards as the standard governing whether MDE is accessible and establish one of the proposed rule’s key requirements: that subject to applicable limitations and defenses, all MDE that public entities purchase, lease, or otherwise acquire after the effective date must meet the MDE Standards unless and until the public entity already has a sufficient amount of accessible MDE to satisfy the scoping requirements of the proposed rule.

As explained above in more detail, the MDE Standards include technical criteria for equipment that is used when patients are either (1) in a supine, prone, or side-lying position; (2) in a seated

<sup>54</sup> NCD Report at 14.

<sup>55</sup> *Id.* at 52.

<sup>56</sup> See 28 CFR 35.130(b)(7).

<sup>57</sup> See U.S. Dep’t of Just., Civ. Rts. Div., *Access to Medical Care for Individuals with Mobility Disabilities*, <https://www.ada.gov/resources/medical-care-mobility/> [<https://perma.cc/UH8Y-NZWL>] (June 26, 2020).

<sup>58</sup> See generally 28 CFR 35.151.

position; (3) in a wheelchair; or (4) in a standing position. They also contain standards for supports, communication, and operable parts. In addition, the MDE Standards also contain requirements for equipment to be compatible with patient lifts where a patient would transfer under positions (1) and (2) above.

Consistent with the language in 29 U.S.C. 794f(b), MDE covered under this subpart includes examination tables, examination chairs (including chairs used for eye examinations or procedures, and dental examinations or procedures), weight scales, mammography equipment, x-ray machines, and other radiological equipment commonly used for diagnostic purposes by health professionals. This section covers medical equipment used by health professionals for diagnostic purposes even if it is also used for treatment purposes.

Given the many barriers to health care that people with disabilities encounter due to inaccessible MDE, adopting the MDE Standards will give many people with disabilities an equal opportunity to participate in and benefit from health care services, programs, and activities.

#### § 35.211(b) Scoping

Paragraph (b) proposes scoping requirements for accessible MDE. Accessibility standards generally contain scoping requirements (how many accessible features are needed) and technical requirements (what makes a particular feature accessible). For example, the 2010 ADA Standards provide scoping requirements for how many toilet compartments in a particular toilet room must be accessible and provide technical requirements on what makes these toilet compartments accessible.<sup>59</sup> The MDE Standards issued by the Access Board contain technical requirements, but they do not specify scoping requirements. Rather, the MDE Standards state that “[t]he enforcing authority shall specify the number and type of diagnostic equipment that are required to comply with the MDE Standards.”<sup>60</sup> For the technical requirements to be implemented and enforced effectively, it is necessary for the Department to provide scoping requirements to specify how much accessible MDE is needed for a public entity’s health care service, program, or activity to comply with the ADA.

The scoping requirements that the Department proposes are based on the requirements that the 2010 ADA

Standards establish for accessible patient sleeping rooms and parking in hospitals, rehabilitation facilities, psychiatric facilities, detoxification facilities, and outpatient physical therapy facilities.<sup>61</sup> Because public entities must comply with title II of the ADA, many public entities are likely already familiar with these standards.

According to the 2010 ADA Standards, licensed medical care facilities and licensed long-term care facilities where the period of stay exceeds 24 hours shall provide accessible patient or resident sleeping rooms and disperse them proportionately by type of medical specialty.<sup>62</sup> Where sleeping rooms are altered or added, the sleeping rooms being altered or added shall be made accessible until the minimum number of accessible sleeping rooms is provided.<sup>63</sup> Hospitals, rehabilitation facilities, psychiatric facilities, and detoxification facilities that do not specialize in treating conditions that affect mobility shall have at least 10 percent of their patient sleeping rooms, but no fewer than one, provide specific accessibility features for patients with mobility disabilities.<sup>64</sup> Hospitals, rehabilitation facilities, psychiatric facilities, and detoxification facilities that specialize in treating conditions that affect mobility must have 100 percent of their patient sleeping rooms provide specific accessibility features for patients with mobility disabilities.<sup>65</sup> In addition, at least 20 percent of patient and visitor parking spaces at outpatient physical therapy facilities and rehabilitation facilities specialized in treating conditions that affect mobility must be accessible.<sup>66</sup>

• *Issue 2: The Department seeks public comment on whether and how to apply the existing scoping requirements for patient or resident sleeping rooms or parking spaces in certain medical facilities to MDE and on whether there are meaningful differences between patient or resident sleeping rooms, accessible parking, and MDE that the Department should consider when finalizing the scoping requirements.*

• *Issue 3: The Department seeks public comment on whether different scoping requirements should apply to different types of MDE (e.g., requiring a higher percentage of accessible exam*

*tables and scales than accessible x-ray machines).*

Proposed paragraphs (b)(1) to (3) lay out scoping requirements for this section. Paragraph (b)(1) provides the general requirement for physician’s offices, clinics, emergency rooms, hospitals, outpatient facilities, multi-use facilities, and other medical services, programs, and activities that do not specialize in treating conditions that affect mobility. When these entities use MDE to provide services, programs, or activities, they must ensure that at least 10 percent, but no fewer than one unit, of each type of equipment complies with the MDE Standards. For example, a medical practice with 20 examination chairs would be required to have two examination chairs (10 percent of the total) that comply with the MDE Standards. In a medical practice with five examination chairs, the practice would be required to have one examination chair that complies with the MDE Standards (because every entity covered by this provision must have no fewer than one unit of each type of equipment that is accessible). If a dental practice has one x-ray machine, that x-ray machine would be required to be accessible.

Proposed paragraph (b)(2) provides the scoping requirement for rehabilitation facilities that specialize in treating conditions that affect mobility; outpatient physical therapy facilities; and other medical services, programs, and activities that specialize in treating conditions that affect mobility. This paragraph requires that at least 20 percent of each type of MDE used in these types of services, programs, and activities, but no fewer than one unit of each type of MDE, must comply with the MDE Standards. Because these facilities specialize in treating patients who are likely to need accessible MDE, it is reasonable for them to have more accessible MDE than is required for the health care providers covered by paragraph (b)(1), who do not have the same specialization. The Department considered whether to require 100 percent of MDE in these programs to be accessible, like section 223.2.2 of the 2010 ADA Standards for Accessible Design, which requires that 100 percent of patient sleeping rooms in similar facilities provide specific accessibility features for patients with mobility disabilities. However, the Department is instead proposing a scoping requirement analogous to section 208.2.2 of the 2010 ADA Standards, which requires 20 percent of visitor and patient parking spaces at such facilities to be accessible. The time-limited use of MDE is more analogous to the use of

<sup>61</sup> See 36 CFR pt. 1191, app. B, secs. 208.2.2, 223.2.1, 223.2.2.

<sup>62</sup> See 28 CFR 35.151(h); 36 CFR pt. 1191, app. B, sec. 223.1.

<sup>63</sup> See 36 CFR pt. 1191, app. B, sec. 223.1.1.

<sup>64</sup> See *id.* sec. 223.2.1.

<sup>65</sup> See *id.* sec. 223.2.2.

<sup>66</sup> See *id.* sec. 208.2.2.

<sup>59</sup> See 36 CFR pt. 1191, app. B, sec. 213.3.1.

<sup>60</sup> 36 CFR pt. 1195, app., sec. M201.

parking spaces at a rehabilitation facility than to the use of sleeping rooms. As with parking spaces, several different patients with mobility disabilities could use the same piece of MDE in a day, while patients generally occupy a sleeping room for all or a significant part of the day. Thus, the Department's proposed rule draws on the 2010 ADA Standards' scoping requirements by requiring at least 20 percent (but no fewer than one unit) of each type of equipment in use in facilities that specialize in treating conditions that affect mobility to meet the MDE Standards, and requiring at least 10 percent (but no fewer than one unit) of each type of equipment in use in other facilities to meet the MDE Standards.

- *Issue 4: Because more patients with disabilities may need accessible MDE than need accessible parking, the Department seeks public comment on whether the Department's suggested scoping requirement of 20 percent is sufficient to meet the needs of persons with disabilities.*

- *Issue 5: The Department seeks public comment on any burdens that this proposed requirement or a higher scoping requirement might impose on public entities.*

Paragraph (b)(3) addresses facilities or programs with multiple departments, clinics, or specialties. The current title II ADA regulation requires medical care facilities that do not specialize in the treatment of conditions that affect mobility to disperse the accessible patient sleeping rooms in a manner that is proportionate by type of medical specialty.<sup>67</sup> The proposed rule includes an analogous dispersion requirement. In any facility or program that has multiple departments, clinics, or specialties, where a service, program, or activity utilizes MDE, the accessible MDE required by paragraphs (b)(1) and (2) shall be dispersed proportionately across departments, clinics, or specialties. For example, a hospital that is required to have five accessible x-ray machines cannot place all the accessible x-ray machines in the orthopedics department and none in the emergency department. People with disabilities must have an opportunity to benefit from each type of medical care provided by the public entity that is equal to the opportunity provided to people without disabilities.<sup>68</sup> The proposed rule would

not require public entities to acquire additional MDE, beyond the amount specified in proposed paragraphs (b)(1) and (2), to ensure that accessible MDE is available in every department, clinic, and specialty. The Department believes that this approach is consistent with many provisions of the 2010 ADA Standards.<sup>69</sup> Additionally, the Department believes that if the rule were to require full dispersion across every department, clinic and specialty, it could be difficult to determine whether the scoping requirements have been satisfied. For example, a clinic may be part of a department and also part of a specialty (or include providers with multiple specialties), so calculating the percentages of accessible MDE that each department, clinic, or specialty has could become complex. However, the Department also recognizes that it is critically important for people with disabilities to have access to all types of medical care. Therefore, public entities would still be required to ensure that all of their services, programs, and activities are accessible to and usable by individuals with disabilities, regardless of whether a specific department, clinic, or specialty would be required to acquire accessible MDE under proposed paragraph (b)(3).

- *Issue 6: The Department seeks public comment on whether the proposed approach to dispersion of accessible MDE is sufficient to meet the needs of individuals with disabilities, including the need to receive different types of specialized medical care.*

- *Issue 7: The Department seeks public comment on whether additional requirements should be added to ensure dispersion (e.g., requiring at least one accessible exam table and scale in each department, clinic, or specialty, or requiring each department, clinic, and specialty to have a certain percentage of accessible MDE).*

- *Issue 8: The Department seeks information regarding:*

- (a) *The extent to which accessible MDE can be moved or otherwise shared between clinics or departments.*

- (b) *The burdens that the rule's proposed approach to dispersion or additional dispersion requirements may impose on public entities.*

- (c) *The burdens that the rule's proposed approach to dispersion may impose on people with disabilities e.g., increased wait times if accessible MDE needs to be located and moved; embarrassment, frustration, or*

*impairment of treatment that may result if a patient must go to a different part of a hospital or clinic to use accessible MDE).*

- *Issue 9: The Department seeks public comment on whether higher, lower, or different scoping requirements than those proposed should be established.*

- *Issue 10: The Department seeks public comment on the burden that the proposed scoping requirements would impose on public entities.*

#### § 35.211(c) Requirements for Examination Tables and Weight Scales

Paragraph (c) sets forth specific requirements for examination tables and weight scales. Proposed paragraph (c)(1) would require public entities that use at least one examination table in their service, program, or activity to purchase, lease, or otherwise acquire, within two years after the publication of this part in final form, at least one examination table that meets the requirements of the Standards for Accessible MDE, unless the entity already has one in place. Similarly, proposed paragraph (c)(2) requires public entities that use at least one weight scale in their service, program, or activity, to purchase, lease, or otherwise acquire, within two years after the publication of this part in final form, at least one weight scale that meets the requirements of the Standards for Accessible MDE, unless the entity already has one in place. This requirement is subject to the other requirements and limitations set forth in § 35.211. Thus, this section does not require a public entity to acquire an accessible examination table and an accessible weight scale if doing so would result in a fundamental alteration in the nature of the service, program, or activity or in undue financial and administrative burdens, per § 35.211(e) and (f). In addition, public entities may use designs, products, or technologies as alternatives to those prescribed by the MDE Standards if the criteria set forth in § 35.211(d) are satisfied.

- *Issue 11: The Department seeks public comment on the potential impact of the requirements in paragraph (c) on people with disabilities and public entities, including the impact on the availability of accessible MDE that will be available for purchase and lease. The Department also seeks public comment on whether two years would be an appropriate amount of time for such a requirement and, if two years would not be an appropriate amount of time, what the appropriate amount of time would be.*

<sup>67</sup> 28 CFR 35.151(h). A similar dispersion requirement was not necessary for medical care facilities that specialize in the treatment of conditions that affect mobility, because 100 percent of patient sleeping rooms in those facilities are required to be accessible. See 36 CFR pt. 1191, app. B, sec. 223.2.2.

<sup>68</sup> See 28 CFR 35.130(b)(ii), 35.150(a).

<sup>69</sup> See, e.g., 36 CFR pt. 1191, app. B, secs. 221.2.3, 224.5, 225.3.1, 235.2.1. According to these sections, when the required number of accessible elements has been provided, further dispersion is not required.



#### § 35.211(d) Equivalent Facilitation

Paragraph (d) specifies that a public entity may use designs, products, or technologies as alternatives to those prescribed by the MDE Standards, for example, to incorporate innovations in accessibility. However, this exception applies only where the public entity provides substantially equivalent or greater accessibility and usability than the MDE Standards require. It does not permit a public entity to use an innovation that reduces access below what the MDE Standards would provide. The responsibility for demonstrating equivalent facilitation rests with the public entity.

#### § 35.211(e) Fundamental Alteration and Undue Burden

Paragraph (e) addresses the fundamental alteration and undue financial and administrative burden defenses. While the proposed rule generally requires public entities to adhere to the MDE Standards when newly purchasing, leasing, or otherwise acquiring equipment, it does not require public entities to take steps that would result in a fundamental alteration in the nature of their services, programs, or activities or in an undue financial or administrative burden. These proposed limitations mirror the existing title II regulation at 28 CFR 35.150(a)(3). If a particular action would result in a fundamental alteration or undue burden, the public entity would be obligated to take other action that would not result in such an alteration or such burdens but would nevertheless ensure that individuals with disabilities receive the benefits or services the public entity provides.

#### § 35.211(f) Diagnostically Required Structural or Operational Characteristics

Paragraph (f) incorporates what the Access Board's MDE Standards refer to as a General Exception.<sup>70</sup> The paragraph states that, where a public entity can demonstrate that compliance with the MDE Standards would alter diagnostically required structural or operational characteristics of the equipment, preventing the use of the equipment for its intended diagnostic purpose, compliance with the Standards would result in a fundamental alteration and therefore would not be required. The Department expects that this provision will apply only in rare circumstances.

In such circumstances, the public entity would still be required to take other action that would not result in such an alteration or such burdens but

would nevertheless ensure that individuals with disabilities could receive the services, programs, or activities the public entity provides. For example, the Department has been informed that certain positron emission tomography ("PET") machines cannot meet the MDE Standards' technical requirements for accessibility and still serve their diagnostic function. If this is so, then public entities would not be required to make those PET machines fully accessible, but they would be required to take other action that would enable individuals with disabilities to access PET machines in some other way without fundamentally altering the nature of the service, program, or activity, or imposing an undue financial or administrative burden. Such actions may include assisting patients who use wheelchairs with transferring so that they can receive a PET scan.

• *Issue 12: The Department seeks public comment on whether the proposed exception set forth in § 35.211(f) is needed.*

#### § 35.212 Existing Medical Diagnostic Equipment

In addition to the requirements for newly purchased, leased, or otherwise acquired MDE, proposed § 35.212 requires that public entities address access barriers resulting from a lack of accessible MDE in their existing inventory of equipment. Here the proposed rule adopts an approach analogous to the concept of program accessibility in the existing regulation implementing title II of the ADA.<sup>71</sup> Under this approach, public entities may make their services, programs, and activities available to individuals with disabilities without extensive retrofitting of their existing buildings and facilities that predate the regulations, by offering access to those programs through alternative methods. The Department intends to adopt a similar approach with MDE to provide flexibility to public entities, address financial concerns about acquiring new MDE, and at the same time ensure that individuals with disabilities will have access to public entities' health care services, programs, and activities.

Proposed § 35.212 requires that each service, program, or activity of a public entity, when viewed in its entirety, be readily accessible to and usable by individuals with disabilities. Section 35.212(a)(1) makes clear, however, that a public entity is not required to make each piece of its existing MDE accessible. Like § 35.211(e), § 35.212(a)(2) incorporates the concepts

of fundamental alteration and undue financial and administrative burden. These provisions do not excuse a public entity from addressing the accessibility of the program. If a particular action would result in a fundamental alteration or undue burden, the public entity would still be obligated to ensure that individuals with disabilities are able to receive the public entity's benefits and services.

#### § 35.212(b) Methods

Paragraph (b) sets forth various methods by which public entities can make their services, programs, and activities readily accessible to and usable by individuals with disabilities when the requirements in proposed § 35.211 have not been triggered by the new acquisition of MDE. Of course, the purchase, lease, or other acquisition of accessible MDE may often be the most effective way to achieve program accessibility. However, except as stated in proposed § 35.211, a public entity is not required to purchase, lease, or acquire accessible MDE if other methods are effective in achieving compliance with this subpart.

For example, if doctors at a medical practice have staff privileges at a local hospital that has accessible MDE, the medical practice may be able to achieve program accessibility by ensuring that the doctors see a person with a disability who needs accessible MDE at the hospital, rather than at the local office, so long as the person with a disability is afforded an opportunity to participate in or benefit from the service, program, or activity equal to that afforded to others. Similarly, if a medical practice has offices in several different locations, and one of the locations has accessible MDE, the medical practice may be able to achieve program accessibility by serving the patient who needs accessible MDE at that location. However, such an arrangement would not provide an equal opportunity to participate in or benefit from the service, program, or activity if it was, for example, significantly less convenient for the patient or if the visit to a different location resulted in higher costs for the patient.

Similarly, if the scoping requirements set forth in § 35.211(b) would require a public entity's medical practice to have three height-adjustable exam tables and an accessible weight scale, but the practice's existing equipment includes only one accessible exam table and one accessible scale, then until the practice must comply with § 35.211, the practice could ensure that its services are readily accessible to and usable by people with

<sup>70</sup> 36 CFR pt. 1195, app., sec. M201.2.

<sup>71</sup> 28 CFR 35.150.



disabilities by establishing operating procedures such that, when a patient with a mobility disability schedules an appointment, the accessible MDE can be reserved for the patient's visit. In some cases, a public entity may be able to make its services readily accessible to and usable by individuals with disabilities by using a patient lift or a trained lift team, especially in instances in which a patient cannot or chooses not to independently transfer to the MDE in question.<sup>72</sup>

If the means by which a public entity carries out its obligation under § 35.212(a) to make its service, program, or activity readily accessible to and usable by individuals with disabilities is by purchasing, leasing, or otherwise acquiring accessible MDE, the requirements for newly purchased, leased, or otherwise acquired MDE set forth in § 35.211 would apply.

• *Issue 13: The Department seeks information about other ways that public entities can make their services, programs, and activities readily accessible to and usable by individuals with disabilities when proposed § 35.211 does not apply.*

The Department is also aware that there may be initial supply issues for accessible MDE, particularly if a large number of public entities seek to purchase accessible MDE at the same time. The Department notes that the fundamental alteration and undue financial and administrative burden limitations may apply if supply chain issues hamper the ability of public entities to purchase, lease, or otherwise acquire accessible MDE.

The proposed rule's requirements apply regardless of whether public entities are using MDE that is leased, purchased, or acquired through other means. The Department is aware that some public entities may lease MDE, rather than purchasing it outright. The Department's existing title II regulation, at 28 CFR 35.130(b)(3), provides that a public entity may not, directly or through contractual or other arrangements, use criteria or methods of administration that subject qualified persons with disabilities to discrimination on the basis of disability. The Department's existing title II regulation, at 28 CFR 35.130(b)(1)(i)–(ii), also prohibits a public entity from, directly or through contractual or other arrangements, denying a qualified individual with a disability the opportunity to participate in or benefit

from a service or affording a qualified individual with a disability an opportunity to participate in or benefit from a service that is not equal to the opportunity afforded others. Under these longstanding regulatory provisions, the manner in which a public entity acquires its equipment does not alter the entity's obligation to provide an accessible program, service, or activity. The proposed rule's requirements also apply if the public entity contracts with a third party to provide medical programs, services, or activities.

• *Issue 14: The Department seeks information regarding public entities' leasing practices, including how many and what types of public entities use leasing, rather than purchasing, to acquire MDE; under what circumstances public entities lease equipment; whether leasing is limited to certain types of equipment (e.g., costlier and more technologically complex types of equipment); and the typical length of public entities' MDE lease agreements.*

• *Issue 15: The Department seeks information regarding whether there is a price differential for MDE lease agreements for accessible equipment.*

• *Issue 16: The Department seeks information regarding any methods that public entities use to acquire MDE other than purchasing or leasing.*

Medical Equipment Used for Treatment, not Diagnostic, Purposes

Many types of medical equipment other than MDE are used in the provision of health care. The accessibility, or lack thereof, of these types of equipment can determine whether people with disabilities have an equal opportunity to participate in and benefit from health services, programs, and activities. This non-diagnostic medical equipment may be used by public entities and includes, for example, devices intended to be used for therapeutic or rehabilitative care such as treatment tables and chairs for oncology, obstetrics, physical therapy, and rehabilitation medicines; lifts; infusion pumps used for dispensing chemotherapy drugs, pain medications, or nutrients into the circulatory system; dialysis chairs used while a patient's blood is pumped between a patient and a dialyzer; other tables or chairs designed for highly specialized procedures; general exercise and rehabilitation equipment used while seated or standing; and ancillary equipment<sup>73</sup> needed to ensure the

safety and comfort of patients in the use of medical equipment.<sup>74</sup> Although the MDE Standards do not address non-diagnostic medical equipment, certain types of other medical equipment that are not diagnostic in purpose may still fall into the technical criteria categories set out by the MDE Standards (equipment used in (1) supine, prone, or side-lying position, (2) seated position, (3) while seated in a wheelchair, and (4) standing position; certain technical requirements concerning methods of communication and operable parts). As noted above, equipment used for both diagnostic purposes and other purposes is MDE if it otherwise meets the definition of MDE.

The Department is considering adding a provision establishing that when the MDE Standards contain technical standards that can be applied to a particular piece of non-diagnostic medical equipment, the requirements set forth in §§ 35.210 through 35.213 apply to the non-diagnostic medical equipment at issue. Although the MDE Standards were promulgated by the Access Board in response to a statutory mandate to provide standards specific to diagnostic equipment, public entities have an obligation under title II to provide equal opportunity to benefit from medical care of all types, including through the use of equipment that does not satisfy the definition of MDE. The Department seeks comment on whether to apply the Access Board's MDE Standards to non-diagnostic equipment—for example, because the relevant characteristics of some types of non-diagnostic equipment may be sufficiently similar to MDE to warrant applying the same standards—and if there is adequate justification for applying the MDE Standards' technical specifications to non-diagnostic equipment, which non-diagnostic equipment should be covered. For example, infusion chairs used only to dispense chemotherapy drugs are not used for diagnostic purposes and therefore would not fall under the definition of MDE. But if the MDE Standards contained technical standards that could be applied to infusion chairs, the requirements set forth in §§ 35.210 through 35.213 could apply to such equipment. The Department seeks public comment on whether this rule should apply to medical equipment that

<sup>72</sup> See U.S. Dep't of Just., Civ. Rts. Div., *Access to Medical Care for Individuals with Mobility Disabilities* (June 26, 2020), [https://www.ada.gov/medicare\\_mobility\\_ta/medicare\\_ta.htm](https://www.ada.gov/medicare_mobility_ta/medicare_ta.htm) [<https://perma.cc/UH8Y-NZWL>].

<sup>73</sup> Ancillary equipment may include equipment such as cushions, bolsters, straps, sliding boards, or other items used to facilitate transfers and to help position patients.

<sup>74</sup> See U.S. Access Board, Medical Diagnostic Equipment Accessibility Standards Advisory Committee, *Advancing Equal Access to Diagnostic Services: Recommendations on Standards for the Design of Medical Diagnostic Equipment for Adults with Disabilities* (Dec. 6, 2013), <https://www.access-board.gov/advisory-committee-reports/mde/mde-report/> [<https://perma.cc/L2WC-S89L>].

is not used for diagnostic purposes, and if so, in what situations it should apply.

- *Issue 17: If this rule were to apply to medical equipment that is not used for diagnostic purposes:*

- *Should the technical standards set forth in the Standards for Accessible Medical Diagnostic Equipment be applied to non-diagnostic medical equipment, and if so, in what situations should those technical standards apply to non-diagnostic medical equipment?*

- *Are there particular types of non-diagnostic medical equipment that should or should not be covered?*

#### § 35.213 Qualified Staff

The proposed rule requires public entities to ensure that their staff are able to successfully operate accessible MDE, assist with transfers and positioning of individuals with disabilities, and carry out the program access obligation with respect to existing MDE. This will enable public entities to carry out their obligation to make the programs, services, and activities that they offer through or with the use of MDE readily accessible to and usable by individuals with disabilities. The Department believes that public entities must have, at all times when services are provided to the public, appropriate and knowledgeable personnel who can operate MDE in a manner that ensures services are available and timely provided. Often, the most effective way for public entities to ensure that their staff are able to successfully operate accessible MDE is to provide staff training on the use of MDE.

- *Issue 18: The Department seeks public comment on this proposal, as well as any specific information on:*

- *The effectiveness of programs used by public entities in the past to ensure that their staff is qualified;*

- *Any information on the costs associated with such programs; and*

- *Whether there are any barriers to complying with this proposed requirement, and if so, how they may be addressed.*

#### IV. Regulatory Process Matters

The Department has examined the likely economic and other effects of this proposed rule addressing the accessibility of MDE under applicable Executive Orders, Federal administrative statutes (e.g., the Regulatory Flexibility Act, Paperwork Reduction Act, and Unfunded Mandates Reform Act) and other regulatory guidance.<sup>75</sup>

<sup>75</sup> See E.O. 13563, 76 FR 3821 (Jan. 21, 2011); E.O. 13272, 67 FR 53461 (Aug. 13, 2002); E.O. 13132, 64 FR 43255 (Aug. 4, 1999); E.O. 12866, 58 FR 51735

As discussed previously, the purpose of this proposed regulation is to revise the regulations implementing title II of the ADA to establish specific requirements, including the adoption of specific technical standards, for making accessible the services, programs, and activities offered by State and local governments to the public through their medical diagnostic equipment.

The Department has carefully crafted this proposed regulation to apply the protections of title II of the ADA in the most economically efficient manner possible. The Office of Management and Budget (OMB), Office of Information and Regulatory Affairs, has determined that this regulatory action is significant. As such, the Department has undertaken a Preliminary Regulatory Impact Analysis (PRIA) pursuant to Executive Order 12866, as amended by Executive Order 14094. The Department has undertaken an initial Regulatory Flexibility Analysis as specified in § 603(a) of the Regulatory Flexibility Act (RFA). The results of both of these analyses are set forth below. Lastly, the Department does not believe that this proposed regulation will have any impact—significant or otherwise—relative to the Paperwork Reduction Act, the Unfunded Mandates Reform Act, or the federalism principles outlined in Executive Order 13132.

##### A. Preliminary Regulatory Impact Analysis Summary

The Department has prepared a PRIA for this rulemaking. This summary of the PRIA provides an overview of the Department's initial economic analysis. The full PRIA will be made available at <https://www.ada.gov/assets/pdfs/mde-pria.pdf>.

The Department estimates that this title II ADA proposed regulation would affect 6,905 public entities.<sup>76</sup> The Department quantifies incremental costs that affected entities may incur in (1) purchasing or leasing accessible MDE and (2) ensuring that qualified staff operate MDE. The Department also quantifies incremental benefits that people with mobility disabilities may enjoy due to higher shares of accessible

(Sept. 30, 1993), as amended by E.O. 14094, 88 FR 21879 (Apr. 6, 2023); Regulatory Flexibility Act of 1980 (RFA), as amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), 5 U.S.C. 601 *et seq.*; Paperwork Reduction Act (PRA), 44 U.S.C. 3501 *et seq.*; Unfunded Mandates Reform Act of 1995, 2 U.S.C. 1501 *et seq.*; OMB Circular A–4 (Sept. 17, 2003).

<sup>76</sup> The estimate of 6,905 public entities comes from the Department of Health and Human Services and the Centers for Medicare & Medicaid Services, based on information in the U.S. Census Bureau's 2019 SUBS Annual Data Table by Establishment Industry, U.S. & states, 6-digit NAICS. See Table 2 of the PRIA for more information.

MDE, which yield improved health outcomes. In addition, the Department discusses other benefits flowing from the proposed rule that cannot be quantified due to lack of data or other methodological reasons.

Table 1 below summarizes findings of the economic impact analysis of the likely incremental monetized costs and benefits of the proposed rule, on an annualized basis. All monetized costs and benefits are estimated for a 10-year period using a discount rate of 3 or 7 percent.

TABLE 1—ANNUALIZED VALUE OF MONETIZED COSTS AND BENEFITS UNDER THE PROPOSED RULE OVER A 10-YEAR PERIOD IN 2022 DOLLARS

[Millions]<sup>77</sup>

	Discount rate (3 percent)	Discount rate (7 percent)
Monetized Incremental Costs .....	\$38.5	\$38.7
Monetized Incremental Benefits .....	7.7	4.8

In addition to these monetized benefit estimates, the PRIA discusses potential enormous unquantified benefits under the proposed rule. The Department expects that the proposed rule will result in a myriad of benefits for individuals with mobility disabilities flowing from greater access to health care and a reduction in discriminatory actions, such as the successful drug dosing for persons with disabilities who will now be able to be weighed and given proper drug regimens due to accessible weight scales, and the removal of multiple causes of loss of self-esteem, frustration, and embarrassment.

As further discussed in the PRIA, there are likely no public entities in the healthcare sector that do not receive some form of Federal financial assistance. Therefore, all or virtually all entities that are subject to title II of the ADA are also subject to section 504 of the Rehabilitation Act. Further, as also noted in the PRIA, title II and section 504 impose parallel requirements, and courts have interpreted them to be consistent. Maintaining that consistency, this rule under title II

<sup>77</sup> In addition to these specific point estimates, the Department in the PRIA reports a full range of cost estimates of \$18.6 million to \$68.6 million at a 3 percent discount rate, and a full range of cost estimates of \$18.7 million to \$68.8 million at a 7 percent discount rate. The PRIA reports a full range of benefit estimates of \$5.1 million to \$10.2 million at a 3 percent discount rate, and a full range of benefit estimates of \$3.2 million to \$6.4 million at a 7 percent discount rate.

imposes virtually the same obligations on public entities as HHS's rule imposes under section 504.

If we take as an alternative baseline the prior adoption of HHS's section 504 rule, assuming it is finalized, public entities will incur no additional costs to comply with title II as to accessible MDE. Entities that comply with the section 504 rule as to MDE will necessarily comply with the title II rule as well.

Under this alternative baseline, it also follows that the title II rule would engender no affirmative benefits with regard to accessible MDE. However, the title II rule could potentially avert significant administrative or transaction costs. Absent the proposed rule setting technical standards and scoping requirements for accessible MDE under title II of the ADA, courts might interpret title II to impose obligations on public entities that differ in some respects from those under section 504. Such differences would result in confusion, uncertainty, duplication, litigation, and increased compliance costs for regulated entities. One advantage of adopting the title II rule is thus avoidance of these pitfalls.

The PRIA includes both quantitative and qualitative discussions of regulatory alternatives directed toward the same goals while imposing lower costs. The PRIA concludes that the proposed rule maximizes net benefits to society while also achieving the regulatory goals.

The Department has examined the impact of the proposed rule on small entities as required by the RFA. For the purpose of this analysis, impacted small entities are independent State and local governmental units in the United States that serve a population less than 50,000.<sup>78</sup> Based on this definition, the Department estimates, in the PRIA at Table 13, a total of 38,514 small governmental entities, of which less than 7 percent have public entities that would be required to purchase accessible MDE. The PRIA estimates the annualized costs of the proposed rule at no more than 1 percent of the annual revenues of small government entities. The Department thus certifies that the proposed rule will not have a significant economic impact on a substantial number of small entities. The PRIA contains further data and analysis under the RFA.

#### *B. Executive Order 13132: Federalism*

Executive Order 13132 requires executive branch agencies to consider whether a proposed rule will have federalism implications. That is, the rulemaking agency must determine whether the rule is likely to have substantial direct effects on State and local governments, the relationship between the Federal government and the States and localities, or the distribution of power and responsibilities among the different levels of government. If an agency believes that a proposed rule is likely to have federalism implications, it must consult with State and local government officials about how to minimize or eliminate the effects.

Title II of the ADA covers State and local government services, programs, and activities, and, therefore, has some federalism implications. State and local governments have been subject to the ADA since 1991, and the majority of them have also been required to comply with the requirements of section 504. Hence, the ADA and the title II regulations are not novel for State and local governments. This proposed rule will preempt State laws affecting entities subject to the ADA only to the extent that those laws provide less protection for the rights of individuals with disabilities. This proposed rule does not invalidate or limit the remedies, rights and procedures of any State laws that provide greater or equal protection for the rights of individuals with disabilities. To minimize any potential conflicts, the Department believes it is prudent to consult with public entities about the potential federalism implications of the proposed title II regulation.

The Department intends to amend the regulations in a manner that meets the objectives of the ADA while also minimizing conflicts between State law and Federal interests. The Department is now soliciting comments from State and local officials and their representative national organizations through this NPRM.

• *Issue 19: The Department seeks public comment on the potential federalism implications of the proposed rule, including whether the proposed rule may have direct effects on State and local governments, the relationship between the Federal government and the States, or the distribution of power and responsibilities among the various levels of government.*

#### *C. National Technology Transfer and Advancement Act of 1995*

The National Technology Transfer and Advancement Act of 1995 (NTTAA) directs that, as a general matter, all Federal agencies and departments shall use technical standards that are developed or adopted by voluntary consensus standards bodies, which are private, generally nonprofit organizations that develop technical standards or specifications using well-defined procedures that require openness, balanced participation among affected interests and groups, fairness and due process, and an opportunity for appeal, as a means to carry out policy objectives or activities.<sup>79</sup> In addition, the NTTAA directs agencies to consult with voluntary, private sector, consensus standards bodies and requires that agencies participate with such bodies in the development of technical standards when such participation is in the public interest and is compatible with agency and departmental missions, authorities, priorities, and budget resources.<sup>80</sup>

The Department is proposing to adopt the Standards for Accessible Medical Diagnostic Equipment issued by the Access Board to apply to the purchase and lease of MDE by public entities. These MDE Standards were adopted by the U.S. Access Board in 2017 after a five-year review period that included participation by an Advisory Committee composed of representatives from the health care industry, architects, persons with disabilities, and organizations representing a variety of interested stakeholders. The MDE Standards were developed after extensive notice and comment. The development of these standards was required by section 510 of the Rehabilitation Act of 1973, as amended, and were developed with the participation of the Food and Drug Administration. They have gained wide recognition in the United States. The Department is unaware of any privately developed standards created with the same wide participation and open process. As a result, the Department believes that it is appropriate to use these MDE Standards for this rule.

• *Issue 20: The Department seeks public comment on the Standards for Accessible Medical Diagnostic Equipment and whether there are any other standards for accessible medical diagnostic equipment that the Department should consider.*

<sup>78</sup> 5 U.S.C. 601(5) and Small Business Admin., *A Guide for Government Agencies: How to Comply with the Regulatory Flexibility Act* (Aug. 2017), <https://advocacy.sba.gov/wp-content/uploads/2019/06/How-to-Comply-with-the-RFA.pdf> [<https://perma.cc/6BFB-2QWH>].

<sup>79</sup> Public Law 104–113, sec. 12(d)(1) (15 U.S.C. 272 note).

<sup>80</sup> *Id.* sec. 12(d)(2).

### D. Plain Language Instructions

The Department makes every effort to promote clarity and transparency in its rulemaking. In any regulation, there is a tension between drafting language that is simple and straightforward and drafting language that gives full effect to issues of legal interpretation. The Department operates a toll-free ADA Information Line at (800) 514-0301 (voice); (800) 514-0383 (TTY) that the public is welcome to call to get assistance understanding anything in this proposed rule. If any commenter has suggestions for how the regulation could be written more clearly, please contact Rebecca B. Bond, Chief, Disability Rights Section, whose contact information is provided in the introductory section of this proposed rule entitled, **FOR FURTHER INFORMATION CONTACT**.

### E. Paperwork Reduction Act

Under the Paperwork Reduction Act of 1995 (PRA), no person is required to respond to a “collection of information” unless the agency has obtained a control number from OMB.<sup>81</sup> This proposed rule does not contain any collections of information as defined by the PRA.

### F. Unfunded Mandates Reform Act

Section 4(2) of the Unfunded Mandates Reform Act of 1995, 2 U.S.C. 1503(2), excludes from coverage under that Act any proposed or final Federal regulation that “establishes or enforces any statutory rights that prohibit discrimination on the basis of race, color, religion, sex, national origin, age, handicap, or disability.” Accordingly, this rulemaking is not subject to the provisions of the Unfunded Mandates Reform Act.

### List of Subjects in 28 CFR Part 35

Administrative practice and procedure, Buildings and facilities, Civil rights, Individuals with disabilities, State and local requirements.

### V. Proposed Regulatory Text

By the authority vested in me as Attorney General by law, including 5 U.S.C. 301; 28 U.S.C. 509, 510; 42 U.S.C. 12134, 12131, and 12205a of the Americans with Disabilities Act, as amended, and for the reasons set forth in Appendix A to 28 CFR part 35, chapter I of title 28 of the Code of Federal Regulations is proposed to be amended as follows—

## PART 35—NONDISCRIMINATION ON THE BASIS OF DISABILITY IN STATE AND LOCAL GOVERNMENT SERVICES

■ 1. The authority citation for part 35 continues to read as follows:

**Authority:** 5 U.S.C. 301; 28 U.S.C. 509, 510; 42 U.S.C. 12134, 12131, and 12205a.

### Subpart A—General

■ 2. Amend § 35.104 by adding the following definitions of “medical diagnostic equipment” and “Standards for Accessible Medical Diagnostic Equipment” in alphabetical order:

#### § 35.104 Definitions.

\* \* \* \* \*

*Medical diagnostic equipment* (“MDE”) means equipment used in, or in conjunction with, medical settings by health care providers for diagnostic purposes. MDE includes, for example, examination tables, examination chairs (including chairs used for eye examinations or procedures, and dental examinations or procedures), weight scales, mammography equipment, x-ray machines, and other radiological equipment commonly used for diagnostic purposes by health professionals.

\* \* \* \* \*

*Standards for Accessible Medical Diagnostic Equipment* (“Standards for Accessible MDE”) means the standards at 36 CFR part 1195, promulgated by the Architectural and Transportation Barriers Compliance Board under section 510 of the Rehabilitation Act of 1973, as amended, in effect as of the date of promulgation of the final version of this rule, found in the Appendix to 36 CFR part 1195.

\* \* \* \* \*

### Subpart I—Accessible Medical Diagnostic Equipment

■ 3. Add new subpart I to read as follows:

#### Subpart I—Accessible Medical Diagnostic Equipment

Sec.

35.210 Requirements for medical diagnostic equipment.

35.211 Newly purchased, leased, or otherwise acquired medical diagnostic equipment.

35.212 Existing medical diagnostic equipment.

35.213 Qualified staff.

35.214–35.219 [Reserved]

#### § 35.210 Requirements for medical diagnostic equipment.

No qualified individual with a disability shall, on the basis of disability, be excluded from

participation in or be denied the benefits of the health care services, programs, or activities of a public entity offered through or with the use of medical diagnostic equipment (MDE), or otherwise be subjected to discrimination by any public entity because the public entity’s MDE is not readily accessible to or usable by persons with disabilities.

#### § 35.211 Newly purchased, leased, or otherwise acquired medical diagnostic equipment.

(a) *Requirements for all newly purchased, leased, or otherwise acquired medical diagnostic equipment.* All MDE that public entities purchase, lease, or otherwise acquire more than 60 days after the publication of this part in final form shall, subject to the requirements and limitations set forth in this section, meet the Standards for Accessible MDE, unless and until the public entity satisfies the scoping requirements set forth in paragraph (b) of this section.

(b) *Scoping requirements.*

(1) *General requirement for medical diagnostic equipment.* Where a service, program, or activity of a public entity, including physicians’ offices, clinics, emergency rooms, hospitals, outpatient facilities, and multi-use facilities, utilizes MDE, at least 10 percent of the total number of units, but no fewer than one unit, of each type of equipment in use must meet the Standards for Accessible MDE.

(2) *Facilities that specialize in treating conditions that affect mobility.* In rehabilitation facilities that specialize in treating conditions that affect mobility, outpatient physical therapy facilities, and other services, programs, or activities that specialize in treating conditions that affect mobility, at least 20 percent, but no fewer than one unit, of each type of equipment in use must meet the Standards for Accessible MDE.

(3) *Facilities with multiple departments.* In any facility or program with multiple departments, clinics, or specialties, where a service, program, or activity uses MDE, the facility shall disperse the accessible MDE required by paragraphs (b)(1) and (2) of this section in a manner that is proportionate by department, clinic, or specialty using MDE.

(c) *Requirements for examination tables and weight scales.* Within two years after the publication of this part in final form, public entities shall, subject to the requirements and limitations set forth in this section, purchase, lease, or otherwise acquire the following, unless the entity already has them in place:

(1) At least one examination table that meets the Standards for Accessible

<sup>81</sup> 44 U.S.C. 3501 *et seq.*

MDE, if the public entity uses at least one examination table; and

(2) At least one weight scale that meets the Standards for Accessible MDE, if the public entity uses at least one weight scale.

(d) *Equivalent facilitation.* Nothing in these requirements prevents the use of designs, products, or technologies as alternatives to those prescribed by the Standards for Accessible MDE, provided they result in substantially equivalent or greater accessibility and usability of the health care service, program, or activity. The responsibility for demonstrating equivalent facilitation rests with the public entity.

(e) *Fundamental alteration and undue burdens.* This section does not require a public entity to take any action that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens. In those circumstances where personnel of the public entity believe that the proposed action would fundamentally alter the service, program, or activity or would result in undue financial and administrative burdens, a public entity has the burden of proving that compliance with paragraph (a) or (c) of this section would result in such alteration or burdens. The decision that compliance would result in such alteration or burdens must be made by the head of a public entity or their designee after considering all resources available for use in the funding and operation of the service, program, or activity, and must be accompanied by a written statement of the reasons for reaching that conclusion. If an action would result in such an alteration or such burdens, a public entity shall take any other action that would not result in such an alteration or such burdens but would nevertheless ensure that individuals with disabilities receive the benefits or services provided by the public entity.

(f) *Diagnostically required structural or operational characteristics.* A public entity meets its burden of proving that compliance with paragraph (a) or (c) of this section would result in a fundamental alteration under paragraph (e) if it demonstrates that compliance with paragraph (a) or (c) of this section would alter diagnostically required structural or operational characteristics of the equipment and prevent the use of the equipment for its intended diagnostic purpose. This paragraph does not excuse compliance with other technical requirements where compliance with those requirements does not prevent the use of the equipment for its diagnostic purpose.

#### **§ 35.212 Existing medical diagnostic equipment.**

(a) *Accessibility.* A public entity shall operate each service, program, or activity offered through or with the use of MDE so that the service, program, or activity, in its entirety, is readily accessible to and usable by individuals with disabilities. This paragraph does not—

(1) Necessarily require a public entity to make each of its existing pieces of MDE accessible to and usable by individuals with disabilities; or

(2) Require a public entity to take any action that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens. In those circumstances where personnel of the public entity believe that the proposed action would fundamentally alter the service, program, or activity or would result in undue financial and administrative burdens, a public entity has the burden of proving that compliance with § 35.212(a) of this part would result in such alteration or burdens. The decision that compliance would result in such alteration or burdens must be made by the head of a public entity or their designee after considering all resources available for use in the funding and operation of the service, program, or activity, and must be accompanied by a written statement of the reasons for reaching that conclusion. If an action would result in such an alteration or such burdens, a public entity shall take any other action that would not result in such an alteration or such burdens but would nevertheless ensure that individuals with disabilities receive the benefits or services, programs, and activities provided by the public entity.

(3) A public entity meets its burden of proving that compliance with § 35.211(a) or (c) of this part would result in a fundamental alteration under paragraph (a)(2) if it demonstrates that compliance with § 35.211(a) or (c) of this part would alter diagnostically required structural or operational characteristics of the equipment and prevent the use of the equipment for its intended diagnostic purpose.

(b) *Methods.* A public entity may comply with the requirements of this section through such means as reassignment of services to alternate accessible locations; home visits; delivery of services at alternate accessible sites; purchase, lease, or other acquisition of accessible MDE; or any other methods that result in making its services, programs, or activities readily accessible to and usable by individuals with disabilities. A public entity is not

required to purchase, lease, or otherwise acquire accessible MDE where other methods are effective in achieving compliance with this section. In choosing among available methods for meeting the requirements of this section, a public entity shall give priority to those methods that offer services, programs, and activities to qualified individuals with disabilities in the most integrated setting appropriate.

#### **§ 35.213 Qualified staff.**

Public entities must ensure their staff are able to successfully operate accessible MDE, assist with transfers and positioning of individuals with disabilities, and carry out the program access obligation regarding existing MDE.

#### **§§ 35.214–35.219 [Reserved]**

Dated: January 8, 2024.

**Merrick B. Garland,**  
*Attorney General.*

[FR Doc. 2024–00553 Filed 1–11–24; 8:45 am]

**BILLING CODE P**

## **DEPARTMENT OF TRANSPORTATION**

### **Federal Motor Carrier Safety Administration**

#### **49 CFR Parts 350, 365, 385, 386, 387, and 395**

**[Docket No. FMCSA–2022–0003]**

**RIN 2126–AC52**

#### **Safety Fitness Determinations**

**AGENCY:** Federal Motor Carrier Safety Administration (FMCSA), Department of Transportation (DOT).

**ACTION:** Notice of data availability; request for comments.

**SUMMARY:** This notice of data availability (NODA) is to alert stakeholders and members of the public about information that FMCSA believes may be relevant to this proceeding. This NODA identifies information the Agency has become aware of and provides an opportunity for public comment. The Agency may consider this information in preparation for further regulatory action following an advance notice of proposed rulemaking (ANPRM).

**DATES:** Comments must be received by February 12, 2024.

**ADDRESSES:** You may submit comments identified by Docket Number FMCSA–2022–0003 using any of the following methods:

- *Federal eRulemaking Portal:* Go to <https://www.regulations.gov/docket/>