



February 12, 2024

*Submitted via regulations.gov*

Rebecca B. Bond  
Chief  
Disability Rights Section  
Civil Rights Division  
U.S. Department of Justice

**Re: Notice of Proposed Rulemaking: DOJ-CRT-2024-0001-0001, RIN 1190-AA78,  
Nondiscrimination on the Basis of Disability: Accessibility of Medical Diagnostic Equipment of  
State and Local Government Entities**

Dear Chief Bond:

The undersigned members of the Consortium for Constituents with Disabilities (CCD) Rights and Health Task Forces and fellow CCD members write to comment on the Notice of Proposed Rulemaking (NPRM), *Nondiscrimination on the Basis of Disability: Accessibility of Medical Diagnostic Equipment of State and Local Government Entities*. CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society free from racism, ableism, sexism, and xenophobia, as well as LGBTQ+ based discrimination and religious intolerance.

This long-awaited proposed rule issued by the U.S. Department of Justice (DOJ or Department) updates, clarifies, and strengthens the implementing regulations for Title II of the Americans with Disabilities Act (ADA), the statute that protects qualified persons with disabilities from discrimination on the basis of disability in services, programs, and activities provided by state and local government entities.<sup>1</sup> Healthcare services provided by state and local government entities, or through state and local government entity funds, are a service, program, and activity subject to Title II of the ADA. Despite the passage of the ADA in 1990, many healthcare services remain inaccessible for people with disabilities due to inaccessible medical equipment. Without enforceable specific technical standards and scoping requirements for medical diagnostic equipment (MDE), people with disabilities will continue to experience discrimination in, and denial of, healthcare services.

On September 14, 2023, the U.S. Department of Health and Human Services (HHS) published a proposed rule, *Discrimination on the Basis of Disability in Health and Human Service Programs or*

*Activities*, to update, clarify, and strengthen the implementing regulation for Section 504 of the Rehabilitation Act of 1973 (Section 504).<sup>2</sup> Section 504 prohibits discrimination against otherwise qualified individuals on the basis of disability in programs and activities that receive federal financial assistance or are conducted by a federal agency. DOJ's proposed rule and HHS' proposed rule recognize that many healthcare providers are subject to both Title II of the ADA and Section 504. In addition, Title II is modeled on Section 504 and they are generally understood to impose similar requirements. The legislative history of the ADA made 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. We agree with the Department that there should be parity between the relevant provisions of Title II of the ADA and Section 504 on MDE standards.

The undersigned members of the CCD Rights and Health Task Forces and fellow CCD members strongly support DOJ's efforts to apply specific requirements to accessible medical equipment. Inaccessible MDE effectively excludes certain people with disabilities from accessing routine examinations and specialized medical care. Due to inaccessible equipment, people with disabilities may be excluded from certain types of exams or treatment, may be delayed in receiving medical treatment because of an inability to access medical care, or receive subpar medical examinations. These issues, and more, can result in undetected medical conditions, exacerbation of known disabilities, and the development of secondary conditions.<sup>3</sup> We agree that regulated entities, physicians, and other healthcare professionals would benefit from specific technical guidance and training on how to fulfill their obligations and make their services accessible. However, some of the proposed requirements do not fully ensure people with disabilities have equal opportunities to access medical services and benefits.

We submit the following responses and additional concerns and recommendations for consideration.

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

The U.S. Access Board issued the Standards for Accessible Medical Diagnostic Equipment (MDE Standards) in 2017.<sup>4</sup> However, since the MDE Standards have not yet been adopted by DOJ nor HHS, they remain unenforceable. We support DOJ's proposal to adopt and incorporate the technical requirements set forth in the MDE Standards. But the Access Board has not yet issued a final rule on MDE low transfer heights. When the initial MDE Standards were issued in 2017, the Board concluded more information was needed. Consequently, the Board recommended a low transfer height of 17 to 19 inches. After two research studies, in May 2023, the Board issued an NPRM proposing a 17-inch low transfer height. The reports strongly supported a 17-inch low transfer height to ensure access and minimize the risk for people with disabilities (patients), providers, and staff that manually transfer wheelchair users. A 17-inch low transfer height allows the greatest number of wheelchair users the opportunity to transfer independently.<sup>5</sup> The 17-inch low transfer height standard received strong support from people with disabilities and disability rights advocates.

On January 24, 2024, the Access Board members voted to send the low transfer height final rule to the U.S. Office of Management and Budget.<sup>6</sup> In anticipation that the Access Board's 17-inch final rule will be published in the imminent future, we recommend DOJ adopt a 17-inch low transfer height requirement in the Title II final rule. Its inclusion within the final ADA Title II MDE standards will give manufacturers a strong incentive to produce compliant equipment that can be acquired by covered entities and avoid further delaying equal opportunity to medical care for people with mobility disabilities.

#### *§ 35.104 Definitions.*

##### *Medical Diagnostic Equipment*

We agree the definition of MDE should include, “equipment used in, or in conjunction with, medical settings by health care providers for diagnostic purposes.” The Department’s proposed list of examples outlines equipment used in medical facilities. However, as discussed in these comments, we urge DOJ to clarify that the definition includes equipment used by providers for diagnostic or treatment purposes regardless of whether that equipment is located in a medical care facility, private residence, or other setting. The explicit inclusion of at-home equipment reinforces that equipment used “in conjunction with” medical services for diagnostic purposes should be accessible for people with disabilities and interpreted broadly. “Medical settings by health care providers for diagnostic purposes” should describe the character of the type of equipment that is covered by the proposed rule, not a limitation on equipment that is located in physical medical facilities. This is particularly true when the use of telemedicine increased sharply during the COVID-19 pandemic, bringing innovations that allow some diagnostic procedures to be performed at home. For some people with disabilities, covered entities may provide diagnostic equipment that is to be used in the person’s residence. To provide equal opportunity to healthcare services and benefits, the MDE definition should encompass all MDE, including equipment used at-home.

##### *Standards for Accessible Medical Diagnostic Equipment*

We agree that the term, “*Standards for Accessible Medical Diagnostic Equipment*,” should refer to the standards promulgated by the Access Board. But the Title II standards should proactively adopt the 17-inch low transfer height requirement. The 2017 low transfer height recommendation of 17 to 19 inches was a placeholder until the Access Board could conduct further research for a specific standard. Since 2017, additional studies were conducted. In May 2023, the Board issued an NPRM proposing a 17-inch low transfer height standard. The reports strongly support a 17-inch low transfer height to ensure access and minimize the risk for individuals with disabilities, providers, and staff that manually transfer wheelchair users. A 17-inch low transfer height allows the greatest number of mobility device users the opportunity to transfer independently. The 17-inch low transfer height standard received strong support from people with disabilities and disability rights advocates. On January 24, 2024, the Access Board

members voted to send the low transfer height final rule to the U.S. Office of Management and Budget. In anticipation that the Access Board's 17-inch final rule will be published in the imminent future, we recommend DOJ adopt a 17-inch low transfer height requirement in the ADA Title II final rule.

*§ 35.210 Requirements for medical diagnostic equipment.*

We agree that covered entities cannot require a person with a disability (patient) to bring a companion to provide assistance. As the Department already concluded, requiring a patient to bring a companion for transfer or other assistance affords treatment that is not equal to that afforded to people without disabilities.<sup>7</sup>

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

We support DOJ's proposal to require all MDE a covered entity purchases, leases, or otherwise acquires after the rule's effective date to be accessible, which aligns with the ADA's scoping requirements for new construction and alterations of facilities.

*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.*

Sixty days is an appropriate amount of time for the requirements to be enforceable and for covered entities to identify and acquire accessible MDE. In addition, two months gives entities time to ensure that all relevant staff are trained and qualified to use the accessible MDE and institute policies and procedures for MDE scheduling, installation, and maintenance.

*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.*

The proposed scoping requirements do not ensure equal access to medical services for people with disabilities. We urge DOJ to remove any distinction in scoping requirements based on the provider, clinic, or department's specialty. People with disabilities must have an equal opportunity to access all medical specialties, even if the specialty does not, on its face, treat conditions that affect mobility. Moreover, the practical application of determining which specialties treat conditions that affect mobility is unworkable. People with disabilities are excluded from various types of medical care due to inaccessible MDE. Due to accessibility barriers, people with disabilities are unable to access urological, OB/GYN, podiatry, optometry, dental, and other essential medical care. Although these specialties are not focused on addressing mobility conditions, access to these services is critical and potentially lifesaving.

Instead, the Department should require *all* MDE purchased, leased, or otherwise acquired after the rule's effective date to be accessible. Accessible MDE is not comparable to parking spaces. If accessible equipment is compared to parking spaces, people with disabilities inevitably receive unequal opportunity to access services. Requiring all medical equipment to be accessible offers equal opportunities for individuals with disabilities as those without disabilities.

Furthermore, DOJ's focus on time-limited use of MDE is misguided. Although multiple people with disabilities may theoretically use some accessible equipment in the same day, their appointment scheduling options are greatly reduced compared to those without disabilities resulting in unequal access. When individuals with disabilities must schedule an appointment only when accessible equipment is available, they face increased burdens, especially when accessible transportation, such as paratransit services, may be limited by time and geographical boundaries. This may exclude an individual with a disability from receiving care. In addition, some equipment, such as dental chairs, may be occupied for a greater length of time than a weight scale. Moreover, sometimes the need for accessible equipment cannot be easily identified in advance of a visit. Also, staff may not be trained in transferring and/or assisting people with disabilities in using accessible medical equipment, such as adjustable examination tables. Many people with limited mobility, especially those with newly acquired disabilities, may not be aware they have to notify their provider in advance that they require accessible equipment, but nonetheless will require it when they arrive for an appointment. If the only exam room with accessible equipment is in use, that person could be forced to reschedule their visit, thus care will be inequitable. If all exam rooms are equipped with accessible equipment no such scheduling problem will arise. In addition, if staff are not trained, willing or able to assist, even if accessible medical equipment is available, medical care is inequitable. Tumors may go undiagnosed, mothers who are pregnant are not weighed and are given the wrong dose of a prescription drug, and unknown infections could go undetected until it is too late.

Furthermore, a 10 percent requirement will inevitably fail to offer equal medical services for the current and future number of Americans with mobility disabilities. As of 2023, 12.1 percent of U.S. adults have a mobility disability.<sup>8</sup> This number does not include children with disabilities. In addition, the U.S. population is aging. The number of older adults in the U.S. are growing in number and expected to outnumber children by 2034.<sup>9</sup> The United States population has also increased by 2.7 million more adults with disabilities in the past two years.<sup>10</sup> This is a significant increase in contrast to previous years. Older adults have higher rates of ambulatory disabilities,<sup>11</sup> and as the population ages, the number who use mobility assistive devices will increase.<sup>12</sup> DOJ can assume that the number of Americans with mobility disabilities will continue to increase. A 10 percent requirement for any specialty does, and will continue, to exclude individuals with disabilities from accessing all medical specialties.

DOJ should instead model the Title II MDE regulations on ADA Title II transportation accessibility requirements.<sup>13</sup> Title II requires all newly purchased and leased vehicles be readily accessible to and usable by people with disabilities (the replacement rule).<sup>14</sup> Despite transportation agencies

urging a lesser percentage due to the cost of manufacturing and acquiring accessible vehicles, disability rights advocates rightly argued that only with 100 percent accessible transportation can people with disabilities have equal access. After the requirement was issued, transportation providers did not incur the higher upfront costs expected because they only needed to acquire accessible vehicles as older vehicles were replaced. In addition, recent research found the benefits of investments in accessible transportation and infrastructure outweighed the costs.<sup>15</sup> We urge DOJ to use a comparable replacement rule and require all newly purchased, leased, or otherwise acquired MDE to be accessible after the rule's effective date. Only with this approach will individuals with disabilities have equal opportunities to access medical benefits and services.

*§ 35.211(a) Requirements for newly purchased, leased, or otherwise acquired medical diagnostic equipment*

We recommend DOJ clarify that any lease renewal is considered a “new” lease, and the equipment must meet the scoping requirements for new equipment. Without this clarification, covered entities may renew leases on existing equipment, further delaying their obligation to acquire accessible equipment.

*§ 35.211(b) Scoping*

*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).*

As outlined in our response to issue two, we recommend DOJ apply the same requirements to all MDE. Only with 100 percent accessible MDE can the requirement for equal opportunity to healthcare services and benefits be attained.

*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.*

As outlined in our response to issue two, we recommend DOJ apply the same requirements to all MDE. Only with 100 percent accessible MDE can the requirement for equal opportunity to healthcare services and benefits be attained.

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

The consideration of financial costs of compliance is unwarranted. When considering additional costs for wheelchair-accessible restrooms, the Department concluded, “the additional benefits that persons with disabilities will derive from greater safety, enhanced independence, and the avoidance of stigma and humiliation—benefits that the Department's economic model could not

put in monetary terms—are, in the Department’s experience and considered judgment, likely to be quite high.”<sup>16</sup> With exceptions for undue financial burdens, covered entities maintain a limited safe haven for circumstances when financial resources are legitimately unavailable to meet the requirements.

Furthermore, if all MDE is accessible, it will reduce administrative burdens on covered entities. When accessible MDE is limited, staff may need to identify the location of accessible equipment and ensure the equipment is available during the appointment time. Accessible medical equipment will increase efficiencies for staff, in that everyone will find greater ease in using it regardless of age, mobility limitations, and other general population limitations. These burdens will be eliminated if accessible equipment is available in all hospitals, clinics, and departments. Per CMS requirements, covered hospitals must maintain a list of equipment inventories and documentation of their maintenance activities.<sup>17</sup> For administrative and practical purposes, DOJ should also require covered entities to maintain a list of accessible equipment in their inventories and systems until all MDE is accessible.

*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.*

As recognized by the Department, full dispersion across every department, clinic, and specialty would make it difficult to determine whether scoping requirements have been satisfied. Without requiring all newly purchased, leased, or otherwise acquired MDE to be accessible, it is administratively impracticable for covered entities and DOJ to identify whether the covered entity is in compliance. Scoping percentages are not an appropriate way for DOJ to ensure equal opportunity to healthcare services and benefits. Using the replacement approach, requiring all newly purchased, leased, or otherwise acquired MDE to be accessible provides an easy test to determine compliance.

Until a covered entity reaches 100 percent accessible MDE, dispersion requirements must still be identified. If this approach is adopted, DOJ should clarify that the dispersion requirements apply only in the interim. Our following comments on dispersion requirements assume they will only be in place until full accessibility is achieved. We again urge DOJ to not distinguish scoping requirements based on the specialty of the provider, clinic, or department.

All types of MDE must be accessible for individuals with disabilities, without requiring separate treatment. While a covered entity is in the process of transitioning towards accessible equipment, all booking systems must indicate where and when accessible equipment is available. If accessible equipment must be shared by multiple departments, the covered entities must ensure the dispersion does not result in unequal treatment, such as a person with a disability needing to go to one floor, building, or clinic to be weighed and another to receive care or treatment. This requirement should be specifically examined if a covered entity’s services are offered in unattached buildings or when clinics or departments are located in buildings not

immediately adjacent to the building where the person with a disability needs to access the service or benefit.

Some equipment may be used by different specialties, such as an accessible weight scale; however, other equipment, including different types of tables and chairs may be designed for specific services. For example, a medical chair used by a podiatrist may likely not be used for OB/GYN services. To comply with the ADA, covered entities must ensure equal access to *all* healthcare services and benefits. Covered entities must treat patients with disabilities equal to patients without disabilities. If it is necessary during the transition period that accommodations are needed, such as accessible transportation to other locations, these must be offered and paid for by the covered entities.<sup>18</sup>

*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).*

Removing the scoping requirements based on specialty eases the burden on DOJ and the covered entities to determine where additional accessible equipment is required. In addition, as the ADA requires all new construction to meet accessibility requirements, covered entities must meet comparable requirements. The purpose of the ADA's new construction and alteration requirements was to move towards equitable and integrated access for people with disabilities in everyday life. DOJ must use the same type of approach for medical services, programs, and activities – equal and integrated access. We urge DOJ to remove any distinct percentages based on specialty. The ADA outlines dispersion requirements for equal access and opportunities. The dispersion requirements outlined below only apply until all equipment is accessible.

For accessible exam tables or chairs, at least one for each specialty must be required until all equipment is accessible. Allowing departments to share accessible equipment may result in unequal opportunities to access services and benefits. An individual with a disability may be forced to traverse to one department to be weighed on an accessible scale then traverse to a different department for the services needed, unlike those without disabilities who can be weighed and receive care in the same department. In addition, various examination tables or chairs may not be used by a different specialty for diagnostic or treatment purposes. At minimum, at least one accessible exam table and weight scale must be located in an adjacent department on the same floor.

Our proposed requirements will also reduce burdens on the covered entities. It will reduce the administrative burden placed on staff tasked with locating, tracking, or obtaining accessible MDE for use during an appointment; reduce the amount of time spent attempting to locate accessible equipment in another department; reduce the risk of the unavailability of accessible equipment due to potential double booking by a different department; reduce the burden on the patient to travel to another floor, unattached building, or a building not immediately adjacent to where



services are rendered; reduce the wait time for people with disabilities and staff to access the equipment; reduce disparate and separate treatment of people with disabilities; and ensure they do not encounter additional barriers to receiving care.

*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).*

Except for some types of accessible exam tables, many types of accessible MDE are not readily moveable. For example, MRI, PET, and CT machines are installed into a stationary physical space. In addition, not all medical chairs or even powered examination tables can be readily moved or sometimes be moved at all. Especially due to the inability to move many types of equipment, DOJ should require each department to have accessible equipment, or equipment that can provide a thorough examination or treatment in each department, or at least have accessible equipment that can be shared and still provide a thorough exam located in an adjacent department on the same floor.

Even for the limited number of moveable MDE, like wheeled accessible exam tables or moveable accessible weight scales, the covered entities would need to use a specialized system for locating the accessible equipment, booking the patient's appointment at the exact time the accessible equipment is available, and ensuring the shared department maintains the equipment in working order. Staff would still then be tasked with locating and moving the accessible equipment or transporting the patient to the department where the accessible equipment is located. For all situations, the covered entities face higher burdens than simply acquiring accessible equipment.

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

As outlined in our comments, DOJ should require higher scoping requirements than proposed – 100 percent accessible MDE.

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

Accessible weight scales are readily available with no substantial additional cost for covered entities. Other types of accessible equipment may pose burdens based on the low transfer height standard, the type of equipment, whether any equipment that meet the standards are currently

on the market, requirements on the manufacturers before they can market specific equipment, and the size of the new accessible equipment. These burdens are outlined in response to the date certain for compliance. DOJ should consider the procurement process for certain MDE. But DOJ should balance these against the potential factors that reduce the covered entities' burden for compliance, such as leasing equipment, the typical length of a lease, whether a lease can be terminated prior to the end of the lease period, whether refurbished equipment can be purchased, and whether the entity can otherwise acquire equipment temporarily that meets the accessibility standards.

*§ 35.211(c) Requirements for examination tables and weight scales*

*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.*

For accessible weight scales, we believe one year is a more appropriate time frame for covered entities to comply with the requirements of § 35.211(c). There are a sufficient number of accessible weight scales on the market and available at varying costs. Covered entities may also purchase or lease refurbished weight scales. In addition, accessible weight scales need minimal staff training to ensure appropriate and safe use. Thus, one year is sufficient for weight scales.

For accessible tables, without a set low transfer height requirement, it cannot be determined whether a sufficient supply is available. For this reason, DOJ must promulgate a 17-inch requirement so manufacturers can further market equipment to meet this standard. After a 17-inch requirement is adopted, a two-year compliance date is appropriate. Once this requirement is set, manufacturers must have sufficient time to design, manufacture, and market accessible examination tables, and covered entities must be given an appropriate, but not delayed, amount of time to procure accessible equipment.

Acquisition timeline requirements must include more than just examination tables and weight scales. The MDE Standards also explicitly cover mammography equipment, x-ray machines, examination chairs, and other radiological and imaging equipment. We strongly recommend DOJ include appropriate acquisition timeframes for other types of MDE.

For some equipment, there are no accessible options on the market. A reasonable, but not delayed, timeframe must be required depending on the type of equipment, such as whether the equipment is an FDA Class I device, which will apply to most equipment, or a higher class that requires FDA 501(k) notification or pre-market approval. In addition, some covered entities, especially larger hospitals, must undergo a lengthy procurement process to acquire new equipment. For a majority of Class I medical equipment, or equipment that meets the DOJ

standards in the final rule, a two-year timeline is reasonable. If no accessible equipment exists, an appropriate, but not delayed, amount of time for acquisition should be required. If the covered entity is unable to comply with the initial date certain due to manufacturing or procedural matters, the covered entity has the affirmative undue burden defense. However, the covered entity cannot continue to maintain the undue burden defense once the equipment is available and can be acquired.

#### *§ 35.211(d) Equivalent Facilitation*

We agree that in all cases where an alternative is necessary, the covered entities must provide a service and benefit that is equivalent, or provides greater accessibility and usability to the affected group of people with disabilities than the MDE Standards. We recommend including the following wording to ensure that equivalent facilitation is not a matter of achieving accessibility only for "enough" people with disabilities. The provider and staff must also engage in an interactive process with the individual, which includes giving due consideration to their preference, and conduct an individualized assessment of the person's needs.<sup>19</sup> Qualified staff must also explain the alternative in plain language and attain the individual's consent to use the alternative option. We suggest the below language in italics be added to the proposed language:

#### *§ 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 *or provides improved access to one group of people with disabilities while reducing access for others*. The responsibility for demonstrating equivalent facilitation rests with the public entity.

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

We agree DOJ should adopt the proposed definition for fundamental alteration and undue burden to be consistent with 28 CFR 35.150(a)(3). The bar for such defenses must be high, and the covered entity must be obligated to take any other action that would not result in a fundamental alteration or undue burden, but would nevertheless ensure that individuals with disabilities receive the services and benefits the entity provides.

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

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

The Access Board's General Exception is not needed. Per the General Exception, MDE shall not be required to comply with one or more applicable requirements where compliance would alter diagnostically required structural or operational characteristics of the equipment and would prevent the use of the equipment for its intended diagnostic purposes.<sup>20</sup> If the MDE must be altered to the point it would prevent its purpose, the fundamental alteration exception would apply. The General Exception also notes the MDE must comply to the maximum extent possible, but this is also unnecessary along with the entire General Exception as the fundamental alteration defense already requires the covered entity to take necessary actions to ensure that individuals with disabilities receive the benefits or services the entity provides. At the very least, if there is a compelling reason to import the Access Board's General Exemption to this rule, it should exclude any reference to § 35.211(c) which only addresses weight scales and exam tables. Scales and exam tables are fundamentally necessary items of medical equipment and should never have "diagnostically required structural or operational characteristics" that clash with accessibility needs.

For equipment that cannot be made accessible due to structural or operational characteristics that trigger the fundamental alteration defense, covered entities must consider all possibilities to ensure the dignity and independence of the individual with a disability. In addition, if lifting a person with a disability provides the greatest accessibility, the covered entities must ensure staff is qualified and properly trained to reduce the risk of injury to the individual or staff. For any patient lifts, we strongly urge DOJ require the covered entity to use a mechanical patient lift to facilitate transfer. Staff must ensure the mechanical lift is available at the time of the individual's appointment. Such equipment must be properly maintained in working order and staff must be trained on how to safely use the equipment to protect the safety of both the person with a disability and staff. In any case where an alternative option is necessary, the provider and staff must engage in an interactive process with the individual, which includes giving due consideration to the person's preference, and conduct an individualized assessment of their needs. Covered entities must also be obligated to take any other action to accommodate the person, which may include providing accessible transportation at no cost.<sup>21</sup>

*§ 35.212 Existing Medical Diagnostic Equipment.*

*§ 35.212(b) Methods*

*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.*

DOJ proposes other options for alternative methods, such as referrals to other hospitals or provider locations. These proposals recognize that alternatives should not be significantly less

convenient or result in higher costs to the patient. Without clear guidance on these requirements, patients are left with uncertainty about their rights. DOJ must also consider other barriers individuals with disabilities may face, for example, limited accessible transportation options or a lack of insurance coverage at the other location. However, there may be circumstances in which the referred location is actually more convenient for the individual. DOJ must provide a clear and defined test for any alternative offered. In any case where an alternative option is necessary, the provider and staff must engage in an interactive process with the person with a disability, which includes giving due consideration to the person's preference, and conduct an individualized assessment of their needs.<sup>22</sup> Covered entities must also be obligated to take any other action to accommodate the individual with a disability, which may include providing accessible transportation at no cost and ensuring that the medical services are fully covered by their insurance.<sup>23</sup> As outlined above, the General Exception should not be included in the final rule as the fundamental alteration defense could apply.

*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.*

Approximately 70 percent of medical practices lease their medical equipment, which provides a lower upfront cost for covered entities and a more flexible option to replace equipment.<sup>24</sup> Lease contracts are generally three to five years in length, but a lessee often has the option to end the lease before the end of the contract. Especially with more technologically complex equipment, covered entities may choose to lease the equipment so they can upgrade to the newest technology at the end of the lease. Lessees may also qualify for federal tax benefits, like IRS Section 179, to reduce costs. To reiterate, should a covered entity renew their lease, the renewed contract must adhere to the same scoping requirements as new equipment to ensure covered entities do not use contractual agreements to avoid regulatory requirements.

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

A financial burden alone is not an affirmative defense for failure to comply with accessibility requirements. As the Department has already concluded, "the additional benefits that persons with disabilities will derive from greater safety, enhanced independence, and the avoidance of stigma and humiliation—benefits that the Department's economic model could not put in monetary terms—are, in the Department's experience and considered judgment, likely to be quite high."<sup>25</sup> Even if a lease agreement for accessible equipment has a higher cost, one benefit of a lease is that the cost is spread out between the lease payments, without a substantially higher upfront cost for the covered entities.

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

Covered entities may acquire MDE through other means than purchasing or leasing. The MDE standards must apply to *any* manner in which entities otherwise acquire or receive MDE that would otherwise fall under this rule, including MDE that is gifted, bequeathed, loaned, purchased on behalf of, or otherwise granted to the covered entities. This should include newly acquired MDE that would otherwise fall under this rule but is gifted, bequeathed, loaned, or otherwise granted temporarily or for a limited timeframe. This MDE must comply with the same standards as newly acquired or leased equipment.

*Medical equipment used for treatment, not diagnostic, purposes.*

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

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

For individuals with disabilities to have equal access, the technical standards must also apply to equipment not used for diagnostic purposes. Without applying the standards to equipment used for treatment, therapeutic, and rehabilitative medical care, people with disabilities will still be denied equal access to all medical services and benefits. If the MDE Standards can be applied to equipment, such as, but not limited to, medical beds, cancer treatment and dialysis chairs; surgical tables and chairs; rehabilitative tables and chairs; and any other medical treatment chairs and tables, people with disabilities will have equal access to the same medical services and benefits offered to those without disabilities. DOJ must also ensure any at-home equipment supplied by a covered entity meets accessibility standards. Such examples would include, but not be limited to, CPAP machines, BiPAP machines, medical beds, blood pressure monitors, and other digital equipment. All at-home equipment should be designed so an individual can use the equipment independently and equally as those without disabilities.

In addition, we urge DOJ, in collaboration with the Access Board, to develop and issue standards for individuals with non-mobility disabilities, including sensory disabilities, intellectual and developmental disabilities, and individuals with multiple disabilities. For example, the introduced bipartisan Medical Device Nonvisual Accessibility Act (H.R. 1328)<sup>26</sup> requires covered devices to meet nonvisual accessibility standards. If passed, DOJ should incorporate similar requirements into the ADA regulations. Although qualified individuals with any type of disability must be offered equal opportunity to access medical services, regulated entities would benefit from specific technical guidance on how to fulfill their obligations and make their services accessible.

*§ 35.213 Qualified staff.*

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

- o The effectiveness of programs used by public entities in the past to ensure that their staff is qualified;*
- o Any information on the costs associated with such programs; and*
- o Whether there are any barriers to complying with this proposed requirement, and if so, how they may be addressed.*

Individuals with disabilities report situations when providers have accessible equipment, but the staff does not know how to operate it. Without proper staff training, the accessible equipment is useless and both the individual and staff are at risk of injury. We strongly urge DOJ to require comprehensive staff training for the safe use of accessible MDE, including training on effective communication with people with disabilities in plain language. All staff must be trained to safely use accessible MDE so the person can use it independently. The cost of this training should be minimal, especially in comparison to the cost of an injury to individuals with disabilities or personnel. Hospital staff have a higher rate of injuries, even when compared to manufacturing and construction workers.<sup>27</sup> Proper training reduces the number of injuries to individuals with disabilities and staff, ultimately reducing costs for covered entities.

We also highly recommend covered entities consult with disability rights organizations and people with disabilities in developing training programs for best practices. Staff must be trained to ensure individuals with disabilities are treated with and afforded respect and dignity. Staff must take the time to fully understand a person with disabilities' capabilities and their degree of independence and capabilities in utilizing medical equipment. In full consultation with individuals with disabilities, staff must formally acknowledge the proficiency such persons have in understanding their own disability and needs in utilizing medical equipment by recording notes within the individual's personal medical records for future reference. Covered entities must also be required to hold consistent refresher trainings for all staff to maintain this necessary knowledge. With their consent, individuals with disabilities can also contribute to the above suggested notes in order to form a corpus of training scenarios for staff and could provide a rich resource for future staff training purposes.

In addition, staff must be trained in what accessible equipment and accommodations may be needed, appropriately book and reserve the use of accessible equipment, and determine whether additional time or staffing may be needed for the appointment due to the use of accessibility features and/or other accommodations. For this process, covered entities must maintain and properly update their accessible equipment inventory.<sup>28</sup>

Barriers to proficient staff training may include a lack of knowledge by the covered entities in general on the use of accessible equipment, best practices in training staff on how to effectively communicate with persons with disabilities, and the types of accommodations needed for people with disabilities. To reduce these burdens, DOJ should provide technical guidance, in consultation

with disability rights organizations and people with disabilities; issue guidance on best practices for staff training, including how to communicate with individuals with disabilities; and provide guidance on best practices for engaging in an interactive process with individuals with disabilities in plain language. Although not covered under Title II, DOJ could collaborate with manufacturers to provide easy to understand instructions on how to use accessible equipment or encourage covered entities to request instructions during the acquisition process. In addition, the covered entities' current booking system may not note which rooms, departments, or locations have accessible equipment. Although covered entities' systems may vary, for ensuring the booking of accessible equipment, this must be required to ensure individuals with disabilities are properly and equally treated. Covered entities must, therefore, maintain an up-to-date list of accessible equipment. Although the transition to a more detailed booking system may potentially result in some minimal upfront costs, it is the only way to ensure staff can properly provide access during the transition to 100 percent accessible equipment.

Thank you for the opportunity to comment on this important proposed rule. The undersigned members of the CCD Rights and Health Task Forces and fellow CCD members urge DOJ to finalize the rule as quickly as possible so people with disabilities are fully able to access medical care and services.

Sincerely,

Access Ready Inc.  
American Association of People with Disabilities  
American Association on Health and Disability  
American Council of the Blind  
American Foundation for the Blind  
American Music Therapy Association  
Association of University Centers on Disabilities  
Autism Society of America  
Autistic Self Advocacy Network  
Autistic Women & Nonbinary Network  
Center for Public Representation  
Christopher & Dana Reeve Foundation  
Cure SMA  
Disability Rights Education and Defense Fund (DREDF)  
Easterseals, Inc.  
Epilepsy Foundation  
Family Voices  
Justice in Aging  
Lakeshore Foundation  
Muscular Dystrophy Association  
National Association of Councils on Developmental Disabilities  
National Disability Rights Network (NDRN)



National Multiple Sclerosis Society  
Paralyzed Veterans of America  
Perkins School for the Blind  
SourceAmerica  
TASH  
The Advocacy Institute  
The Arc of the United States  
United Spinal Association  
World Institute on Disability

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<sup>1</sup> 42 U.S.C. 12132.

<sup>2</sup> U.S. Department of Health and Human Services, Proposed Rule, *Discrimination on the Basis of Disability in Health and Human Service Programs or Activities*, HHS–OCR–2023–0013, RIN 0945–AA15.

<sup>3</sup> National Council on Disability, *Enforceable Accessible Medical Equipment Standards: A Necessary Means to Address the Health Care Needs of People with Mobility Disabilities* (May 20, 2021), available at [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).

<sup>4</sup> 82 FR 2810 (Jan. 8, 2017).

<sup>5</sup> ATBCB-2023-0001-0001 (May 23, 2023).

<sup>6</sup> U.S. Access Board Meeting (Jan. 24, 2024).

<sup>7</sup> See *U.S. v. Barnett Dulaney Perkins Eye Center, PC, and Medical Management Resources Group, L.L.C.*, No. 21-cv-2172-PHX-SRB (Jan. 17, 2023), available at <https://www.justice.gov/media/1268741/dl?inline>.

<sup>8</sup> Centers for Disease Control and Prevention, *Disabilities Impact Us All* (May 2023), <https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html>.

<sup>9</sup> U.S. Census Bureau, *National Senior Citizens Day* (Aug. 21, 2022), available at <https://www.census.gov/newsroom/stories/senior-citizens-day.html>.

<sup>10</sup> U. S. Census Bureau, “Week 60 Household Pulse Survey: July 26 – August 7,” August 16, 2023, available at <https://www.census.gov/data/tables/2023/demo/hhp/hhp60.html>.

<sup>11</sup> U.S. Census Bureau, *Living With Disabilities* (Sept. 30, 2021), available at <https://www.census.gov/library/visualizations/2021/comm/living-with-disabilities.html>.

<sup>12</sup> National Institute on Disability and Rehabilitation Research, U.S. Department of Education, *Mobility Device Use in the United States, Disabled World* (April 22, 2013), available at <https://www.disabled-world.com/disability/statistics/mobility-stats.php>. <https://www.disabled-world.com/disability/statistics/mobility-stats.php> (Note: although the exact number of wheelchair users may be different now versus an older report, the study does show the difference in mobility device users among age groups. The number and percentage of specific device users should not be derived from this report due to changes in the availability of such devices in the past decade).

<sup>13</sup> See 49 C.F.R. §§ 37 – 39.

<sup>14</sup> 49 C.F.R. § 37 Subtit. D, E.

<sup>15</sup> Steer Davies Gleave, U.K. Dep’t for Transport, *Access for All Benefit Research: Impacts of Station Accessibility Improvements 62* (2015), <https://uk.steergroup.com/sites/default/files/2021-03/Access4AllBenefitResearch2015.pdf#page=10>.

<sup>16</sup> Department of Justice, Civil Rights Division, 28 CFR Part 36, RIN 1190–AA44 *Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, Final Rule, Supplementary Information, Additional Benefits of Water Closet Clearance Standards*.

<sup>17</sup> Department of Health & Human Services, Centers for Medicare & Medicaid Services, Office of Clinical Standards and Quality/Survey & Certification Group (Dec. 2011), [https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/SCLetter12\\_07.pdf](https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/SCLetter12_07.pdf).

<sup>18</sup> See 28 CFR 35.130(f) (“A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or

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program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.”).

<sup>19</sup> See U.S. v. Barnet Dulaney Perkins Eye Center, PC, Consent Decree.

<sup>20</sup> 36 CFR pt. 1195, app., sec. M201.2.

<sup>21</sup> See 28 CFR 35.130(f) (“A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.”).

<sup>22</sup> See U.S. v. Barnet Dulaney Perkins Eye Center, PC, Consent Decree.

<sup>23</sup> See 28 CFR 35.130(f) (“A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.”).

<sup>24</sup> See Whitney J. Palmer, Leasing Medical Equipment: A Viable Option for Private Practice, WOLTERS KLUWER (2020), <https://www.wolterskluwer.com/en/expert-insights/leasing-medical-equipment-a-viable-option-for-private-practice>.

<sup>25</sup> Department of Justice, Civil Rights Division, 28 CFR Part 36, RIN 1190-AA44 Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, Final Rule, Supplementary Information, Additional Benefits of Water Closet Clearance Standards.

<sup>26</sup> Medical Device Nonvisual Accessibility Act of 2023, H.R. 1328, 118th Cong. (2023), <https://www.congress.gov/bill/118th-congress/house-bill/1328/text?s=1&r=80&q=%7B%22search%22%3A%5B%22H.R.+6%22%5D%7D>.

<sup>27</sup> Occupational Safety and Health Administration, Facts about Hospital Worker Safety (Sept. 2013), [https://www.osha.gov/sites/default/files/1.2\\_Factbook\\_508.pdf](https://www.osha.gov/sites/default/files/1.2_Factbook_508.pdf).

<sup>28</sup> See Department of Health & Human Services, Centers for Medicare & Medicaid Services, Office of Clinical Standards and Quality/Survey & Certification Group (Dec. 2011), [https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/SCLetter12\\_07.pdf](https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/SCLetter12_07.pdf).