under the Small Business Regulatory Enforcement Fairness Act of 1996.[9]

The effective date for the updated Filer Manual and related rule amendments is August 9, 2024. In accordance with the APA,[10] we find that there is good cause to establish an effective date less than 30 days after publication of these rules. The Commission believes that establishing an effective date less than 30 days after publication of these rules is necessary to coordinate the effectiveness of the updated Filer Manual with the related system upgrades.

VI. Statutory Basis

We are adopting the amendments to Regulation S–T under the authority in Sections 6, 7, 8, 10, and 19(a) of the Securities Act of 1933,[11] Sections 3, 12, 13, 14, 15, 15B, 23, and 35A of the Securities Exchange Act of 1934,[12] Section 319 of the Trust Indenture Act of 1939,[13] and Sections 8, 30, 31, and 38 of the Investment Company Act of 1940.[14]

List of Subjects in 17 CFR Part 232

Incorporation by reference, Reporting and recordkeeping requirements, Securities.

Text of the Amendments

In accordance with the foregoing, title 17, chapter II of the Code of Federal Regulations is amended as follows:

PART 232—REGULATION S–T—GENERAL RULES AND REGULATIONS FOR ELECTRONIC FILINGS

■ 1. The general authority citation for part 232 continues to read as follows:

Authority: 15 U.S.C. 77c, 77f, 77g, 77h, 77j, 77s(a), 77z–3, 77sss(a), 78c(b), 78*l,* 78m, 78n, 78n–1,78*o*(d), 78w(a), 78*ll,* 80a–6(c), 80a–8, 80a–29, 80a–30, 80a–37, 7201 *et seq.;* and 18 U.S.C. 1350, unless otherwise noted.

* * * * *

■ 2. Section 232.301 is revised to read as follows:

§ 232.301 EDGAR Filer Manual.

Filers must prepare electronic filings in the manner prescribed by the EDGAR Filer Manual, promulgated by the Commission, which sets forth the technical formatting requirements for electronic submissions. The requirements for becoming an EDGAR Filer and updating company data are set forth in the EDGAR Filer Manual, Volume I: ''General Information,'' Version 41 (December 2022). The requirements for filing on EDGAR are set forth in the updated EDGAR Filer Manual, Volume II: ''EDGAR Filing,'' Version 70 (July 2024). All of these provisions have been incorporated by reference into the Code of Federal Regulations, which action was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You must comply with these requirements in order for documents to be timely received and accepted. The EDGAR Filer Manual is available for inspection at the Commission and at the National Archives and Records Administration (NARA). The EDGAR Filer Manual is available for website viewing and printing in the Commission's Public Reference Room, 100 F Street NE, Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Operating conditions may limit access to the Commission's Public Reference Room. For information on the availability of the EDGAR Filer Manual at NARA, visit *www.archives.gov/federal-register/cfr/ibr-locations.html* or email *fr.inspection@nara.gov.* The EDGAR Filer Manual may also be obtained from *https://www.sec.gov/edgar/filerinformation/current-edgar-filer-manual.*

By the Commission.

Dated: July 1, 2024.

Vanessa A. Countryman,

Secretary.

[FR Doc. 2024–17563 Filed 8–8–24; 8:45 am]

BILLING CODE 8011–01–P

[9] 5 U.S.C. 804(3)(c).

[10] 5 U.S.C. 553(d)(3).

[11] 15 U.S.C. 77f, 77g, 77h, 77j, and 77s(a).

[12] 15 U.S.C. 78c, 78*l,* 78m, 78n, 78*o,* 78*o*–4, 78w, and 78*ll.*

[13] 15 U.S.C. 77sss.

[14] 15 U.S.C. 80a–8, 80a–29, 80a–30, and 80a–37.

DEPARTMENT OF JUSTICE

28 CFR Part 35

[CRT Docket No. 143; AG Order No. 5982–2024]

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: Final rule.

SUMMARY: The Department of Justice (''Department'') issues this final rule revising the regulation implementing title II of the Americans with Disabilities Act (''ADA''). The rule establishes requirements, including the adoption of specific technical standards and scoping requirements, for making accessible to the public the services, programs, and activities that State and local governments offer through their Medical Diagnostic Equipment (''MDE'').

DATES: This rule is effective October 8, 2024.

FOR FURTHER INFORMATION CONTACT: Rebecca B. Bond, Chief, Disability Rights Section, Civil Rights Division, U.S. Department of Justice, at (202) 307–0663 (voice). 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 TTY) or (833) 610–1264 (TTY). You may obtain copies of this rule in an alternative format by calling the ADA Information Line at (800) 514–0301 (voice) or (833) 610–1264 (TTY). This rule is also available on *www.ada.gov.*

SUPPLEMENTARY INFORMATION:

I. Executive Summary

Title II of the ADA provides that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity (also referred to as a ''State or local government entity'').[1] In this final rule, the Department is revising its title II ADA regulation, 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 (revised as of July 1, 2017) (''MDE Standards'' or ''Standards for Accessible MDE'').[2]

MDE includes equipment like medical examination tables, weight scales, dental chairs, and radiological diagnostic equipment such as mammography machines. Without accessible MDE, individuals with disabilities may not be afforded an equal opportunity to receive medical care,

[1] 42 U.S.C. 12132. The Department uses the phrases ''State and local government entities'' and ''public entities'' interchangeably throughout this rule to refer to ''public entit[ies]'' as defined in 42 U.S.C. 12131(1) that are covered under part A of title II of the ADA.

[2] As discussed in the explanation of § 35.104 in the appendix to this rule, the Department is declining to adopt two sunset provisions in the January 9, 2017, version of the Access Board's MDE Standards codified on July 1, 2017, because, if the Department included those two provisions, part of the Department's rule would lack effect upon publication. Other than those two provisions, the Department is adopting the January 9, 2017, version of the Access Board's MDE Standards, as reflected at 36 CFR part 1195 (revised as of July 1, 2017), in full.

including routine examinations, which could have serious implications for their health. A lack of accessible MDE may also undermine the quality of care that individuals with disabilities receive, delay the provision of medical care, exacerbate existing medical conditions, and increase the likelihood of developing secondary medical conditions.[3] For instance, patients with disabilities have had to forgo Pap smears because they could not safely transfer from their wheelchairs to fixed-height examination tables.[4] Similarly, inaccessible mammography machines have contributed to low breast cancer screening rates for patients with disabilities.[5]

The Access Board issued the MDE Standards under section 510 of the Rehabilitation Act of 1973, 29 U.S.C. 794f (''section 510''). The MDE Standards set forth minimum technical criteria for MDE used in physicians' offices, clinics, emergency rooms, hospitals, and other medical settings to ensure that such equipment is accessible to and usable by individuals with accessibility needs, including people with disabilities.[6] By issuing this rule, the Department is adding a new subpart I to the title II ADA regulation that adopts the MDE Standards and makes them enforceable under title II of the ADA. This will ensure that MDE used by public entities to offer services, programs, and activities at places such as hospitals and health care clinics is accessible to individuals with disabilities.

This rule generally requires all MDE that public entities purchase, lease, or otherwise acquire more than 60 days after this final rule is published to meet the MDE Standards, unless and until the rule's scoping requirements are met. The scoping requirements state that where public entities' services, programs, and activities use MDE, at least 10 percent of the total number of units, but no fewer than 1 unit, of each type of equipment in use must meet the MDE Standards. The scoping requirements further state that 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 1 unit, of each type of equipment in use must meet the MDE Standards. The rule allows public entities to use designs, products, or technologies as alternatives to those prescribed by the MDE Standards, as long as the alternatives provide substantially equivalent or greater accessibility and usability than the MDE Standards require. Facilities with multiple departments, clinics, or specialties must disperse their accessible MDE proportionately. The rule also requires public entities that use examination tables or weight scales to acquire at least one accessible unit of each such category of equipment within two years after this final rule is published.

In addition to adopting the MDE Standards and establishing the requirements described in the preceding paragraph, the rule clarifies that a public entity may not deny services that it would otherwise provide to a patient with a disability, or otherwise discriminate against patients with disabilities, because the public entity's MDE is not readily accessible to or usable by individuals with disabilities. The rule also clarifies that public entities' services, programs, and activities offered through or with the use of MDE must be, in their entirety, readily accessible to and usable by individuals with disabilities. Public entities are not necessarily required to make every unit of MDE accessible to and usable by individuals with disabilities. For example, they may be able to make their services, programs, and activities, in their entirety, readily accessible to and usable by individuals with disabilities by acquiring accessible MDE, delivering services at alternate accessible locations, or conducting home visits. Finally, the rule requires public entities to ensure that their staff can successfully operate accessible MDE, assist with transfers and positioning of individuals with disabilities, and carry out the rule's requirements for existing MDE.

There are limitations on public entities' obligations under this rule. As with the current ADA regulation,[7] this rule does not require public entities to take any action that would constitute a fundamental alteration of the service, program, or activity being offered or cause undue financial and administrative burdens. Public entities are also not required to take any action that would alter their equipment's diagnostically required structural or operational characteristics and prevent the equipment from being used for its intended diagnostic purpose.

More information about what this rule requires is provided in the appendix.

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.[8]

The ADA authorizes the Attorney General to promulgate regulations to carry out the provisions of title II, with the exception of certain matters within the scope of the authority of the Secretary of Transportation.[9] The ADA also authorizes the Attorney General to promulgate regulations to carry out the provisions of title III, which focuses on public accommodations.[10] 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 which adopted the Americans with Disabilities Act Accessibility Guidelines for Buildings and Facilities (''ADA Standards for Accessible Design'').[11]

In 2004, the Department published an advance notice of proposed rulemaking (''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'').[12] The 2004 ANPRM asked for public comment on a range of issues not specifically addressed in the 1991 ADA regulation, including coverage of movable or portable equipment and furniture.[12] The Department subsequently issued a notice of proposed rulemaking (''NPRM'') in 2008.[13] 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.[14] Instead, the Department continued its approach of requiring covered entities to provide accessible equipment and furniture as

[3] 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, 2021) (''NCD Report''), *https://www.ncd.gov/assets/uploads/reports/ncd_medical_equipment_report_508.pdf* [*https://perma.cc/6W4U-TVEX*].

[4] *See id.* at 17.

[5] *See id.* at 18.

[6] 29 U.S.C. 794f(a).

[7] *See, e.g.,* 28 CFR 35.150(a)(3).

[8] 42 U.S.C. 12132.

[9] *Id.* section 12134. Sections 229(a) and 244 of the ADA direct the Secretary of Transportation to issue regulations implementing part B of title II, except for section 223. *See* 42 U.S.C. 12149, 12164.

[10] *Id.* section 12186(b).

[11] 56 FR 35694 (July 26, 1991); 56 FR 35544 (July 26, 1991).

[12] 69 FR 58774–75.

[13] 73 FR 34466 (June 17, 2008).

[14] *Id.* at 34474–75.

needed to comply with the ADA's general nondiscrimination requirements under the Department's existing regulations.[15]

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'').[16] 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.[17] 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.[18] However, in December 2017, the Department withdrew the 2010 ANPRM to reevaluate whether the imposition of specific regulatory standards for the accessibility of nonfixed equipment and furniture was necessary and appropriate.[19]

In 2021, the Department indicated its plan to issue an ANPRM on possible revisions to its ADA regulation to ensure the accessibility of equipment and furniture in public entities' and public accommodations' programs and services.[20] Subsequently, in 2022, the Department decided to bifurcate that rulemaking and announced that it planned to publish a separate ANPRM that solely addressed the accessibility of MDE under both title II and title III.[21] The Department ultimately proceeded with its MDE rulemaking under title II through an NPRM, rather than first issuing an ANPRM.

In the NPRM, published on January 12, 2024, the Department proposed to revise its title II regulation to adopt the Access Board's technical standards and to establish scoping requirements to make accessible to the public the services, programs, and activities that State and local governments offer through their MDE.[22] The Department also published a fact sheet describing the NPRM's proposed requirements in plain language to help ensure that members of the public understood the rule and had an opportunity to provide feedback.[23] The public comment period closed on February 12, 2024. The Department received approximately 200 comments from members of the public, including individuals with disabilities and their family members, public entities, disability advocacy groups, members of the medical community, industry groups, and others. The Department also received two letters from Members of Congress, which addressed issues discussed in many of the other comments submitted on this rulemaking.[24]

The Department is coordinating its publication of this rule with the Department of Health and Human Services (''HHS''). In September 2023, HHS issued an NPRM that addressed the requirements for accessibility of MDE for recipients of Federal financial assistance under section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 (''section 504'').[25] HHS issued its final section 504 rule on May 9, 2024.[26]

Title II is modeled on section 504,[27] 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.[28] 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.[29] The legislative history of the Rehabilitation Act Amendments of 1992 [30] provides that the revisions to the Rehabilitation Act's findings, purpose, and policy provisions are a confirmation of the principles of the ADA,[31] and that these principles are intended to guide the Rehabilitation Act's policies, practices, and procedures.[32] Further, courts interpret the ADA and section 504 consistently.[33] 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 the congressional intent that the two disability rights laws be interpreted consistently, the Department's rule, which applies to public entities subject to title II of the ADA, imposes virtually the same requirements as HHS's rule, which applies to recipients of Federal financial assistance subject to section 504. The Department will continue to consider issues concerning MDE under title III as well as equipment and furniture other than MDE under both titles, although those issues are not the subjects of rulemaking at this time.

B. Legal Foundation for Accessible MDE

This final rule 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.[34] As a result of this mandate and the Department's implementing regulation, public entities must provide accessible equipment and furniture as necessary to comply with title II's reasonable modification, effective communication, and program accessibility requirements.

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[15] *Id.*

[16] *See* Press Release, 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).

[17] 75 FR 43452 (July 26, 2010).

[18] *See* Off. of Mgmt. & Budget, Off. of Info. & 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*].

[19] 82 FR 60932 (Dec. 26, 2017).

[20] *See* Off. of Mgmt. & Budget, Off. of Info. & 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*].

[21] *See* Off. of Mgmt. & Budget, Off. of Info. & 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*].

[22] 89 FR 2183 (Jan. 12, 2024).

[23] U.S. Dep't of Just., Civ. Rts. Div., *Fact Sheet: Notice of Proposed Rulemaking on Accessibility of Medical Diagnostic Equipment, https://www.ada.gov/resources/2024-01-10-mde-nprm/* [*https://perma.cc/R69R-4QBW*].

[24] Sen. Robert P. Casey, Jr., et al., Comment Letter on Proposed Rule Regarding Nondiscrimination on the Basis of Disability: Accessibility of Med. Diagnostic Equip. of State & Loc. Gov't Entities (Mar. 25, 2024), *https://www.regulations.gov/comment/DOJ-CRT-2024-0001-0196* [*https://perma.cc/QB8A-LW5G*]; Rep. Ayanna Pressley, et al., Comment Letter on Proposed Rule Regarding Nondiscrimination on the Basis of Disability: Accessibility of Med. Diagnostic Equip. of State & Loc. Gov't Entities (Apr. 2, 2024), *https://www.regulations.gov/comment/DOJ-CRT-2024-0001-0197* [*https://perma.cc/39MU-PXA5*].

[25] 88 FR 63392 (Sept. 14, 2023).

[26] 89 FR 40066 (May 9, 2024).

[27] *See, e.g.,* H.R. Rep. No. 101–485, pt. 2, at 84 (1990).

[28] *See, e.g.,* 42 U.S.C. 12201(a).

[29] *See* H.R. Rep. No. 101–485, pt. 2, at 84 (1990).

[30] Public Law 102–569, 106 Stat. 4344.

[31] S. Rep. No. 102–357, at 14 (1992).

[32] *See id.; see also* H.R. Rep. No. 102–822, at 81 (1992).

[33] *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).

[34] 42 U.S.C. 12132.

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.[35] 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.[36] These auxiliary aids include the ''[a]cquisition or modification of equipment or devices.'' [37]

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.[38] 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 the fundamental alteration or undue burdens limitations.[39] A public entity may comply with the program accessibility requirement through such means as redesign or acquisition of equipment.[40]

As with many other statutes, the ADA's requirements are broad and its implementing regulations do not include specific standards for every obligation under the statute. This has been the case in the context of the accessibility of MDE under the ADA. While public entities were already required to comply with the ADA with respect to MDE even before this rulemaking, the Department had not adopted technical standards specifying what constitutes accessible MDE.

C. Overview of the Access Board's MDE Standards

Section 510 of the Rehabilitation Act 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.[41] Under the statute, the standards must ensure that such equipment is accessible to and usable by individuals with accessibility needs, including people with disabilities.

In implementing the mandate set forth in section 510 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.[42] The January 9, 2017, revisions were codified on July 1, 2017.[43] The Access Board divides the MDE Standards into four separate technical criteria based on how the equipment is used by the patient: (1) in the supine, prone, or side-lying position; (2) in the seated position; (3) seated in a wheelchair; and (4) in the standing position.[44] 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.[45] 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.[46] 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.[47]

The January 9, 2017, version of the Access Board's MDE Standards contained a temporary standard governing the minimum low height requirement for transfers from diagnostic equipment used by patients in the supine, prone, side-lying, or seated position.[48] Specifically, the temporary standard provided 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. Under this standard, any low transfer height between 17 inches and 19 inches meets the MDE Standards. The January 9, 2017, version of the Access Board's MDE Standards included a sunset provision which stated that the 17-inch to 19-inch low transfer height range would remain in effect only until January 10, 2022.[49]

On May 23, 2023, the Access Board issued an NPRM that proposed replacing the temporary 17-inch to 19-inch low transfer height range with a permanent 17-inch low transfer height standard.[50] On July 25, 2024, the Access Board published a final rule replacing the temporary 17-inch to 19-inch low transfer height range with a permanent 17-inch low transfer height standard. The Department will consider issuing a supplemental rulemaking under title II proposing to adopt the Access Board's updated standard.

D. Need for the Adoption of MDE Standards

While section 510 directs the Access Board to develop standards for accessible MDE, it does not give the Access Board authority to enforce those standards.[51] Compliance with the MDE Standards is mandatory only if an enforcing authority adopts them as mandatory for entities subject to its jurisdiction.[52] By issuing this rule, the Department adopts the MDE Standards under title II of the ADA.

The accessibility of MDE is essential to providing equal access to medical care to people with disabilities. In developing this 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.[53] The

[35] 28 CFR 35.130(b)(7)(i).

[36] *See id.* § 35.160.

[37] *Id.* § 35.104; *see also* 82 FR 2848 (setting forth technical standards for MDE that communicates instructions or other information to the patient).

[38] 28 CFR 35.149.

[39] *Id.* § 35.150(a).

[40] *Id.* § 35.150(b)(1).

[41] 29 U.S.C. 794f(a).

[42] 82 FR 2810. For further detail on the Access Board's extensive deliberative process, see generally Architectural and Transportation Barriers Compliance Board, *Rulemaking Docket: Medical Diagnostic Equipment Accessibility Standards, https://www.regulations.gov/docket/ATBCB-2012-0003/document* [*https://perma.cc/5GZF-8TAZ*].

[43] 36 CFR part 1195 (revised as of July 1, 2017).

[44] *Id.* part 1195, appendix, sections M301–04 (revised as of July 1, 2017).

[45] *See id.* sections M301–02.

[46] *See id.* sections M303–04.

[47] *See id.* sections M305–07.

[48] *See id.* sections M301.2.1, 302.2.1.

[49] *See id.*

[50] 88 FR 33056 (May 23, 2023).

[51] 29 U.S.C. 794f.

[52] *See* 36 CFR 1195.1 (stating that other agencies, referred to as enforcing authorities, may adopt the standards as mandatory requirements for entities subject to their jurisdiction); 36 CFR part 1195, appendix, section M101.3 (revised as of July 1, 2017) (stating that enforcing authorities may include the Department of Justice).

[53] 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,*

Continued

accessibility or inaccessibility of MDE impacts a substantial population—according to an estimate by the Centers for Disease Control and Prevention, as of 2023, approximately 61 million adults lived with a disability in the United States, and 13.7 percent of those individuals had a mobility disability with serious difficulty walking or climbing stairs.[54]

While not all individuals with a mobility disability will require accessible MDE or benefit from it to the same extent, significant portions of this population 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 that involves MDE.[55] In one example, a patient with a disability remained in his wheelchair for the entirety of his annual physical examination, 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.'' [56] In another example, a patient with a disability reported that even if she could be transferred to a standard examination table, extra staff was needed to keep her from falling off the table because 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.[57]

Many individuals who submitted comments on the Department's NPRM agreed that there is a need for a regulation on the accessibility of MDE. Comments from individuals with disabilities and from caregivers included anecdotes describing inadequate care and humiliations that individuals with disabilities had experienced due to a lack of accessible MDE. A young person who uses a wheelchair due to a spinal cord injury wrote that she developed cancer shortly after her injury but that doctors stopped part of her cancer treatment because of a lack of accessible equipment to measure her bone density. Other commenters described having to go to veterinarians' offices to use their larger footprint weight scales, a situation that one commenter described as ridiculous and challenging. In addition to commenters personally impacted by the rulemaking, State and local government entities, medical associations, academic institutions, and disability rights advocacy groups expressed strong support for the rulemaking.

In addition to the comments submitted on the NPRM, many of which described the effect of inaccessible MDE, 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.[58] 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 did not provide the most basic forms 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 examination and treatment equipment, for their facilities.[59] These settlement agreements, and a description of the Barrier-Free Health Care Initiative, are available to the public at *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 disabilities. For example, the Department and HHS jointly issued a technical assistance document on medical care for people with mobility disabilities, addressing how accessible MDE can be critical to ensuring that people with disabilities receive medical services equal to those received by people without disabilities.[60] In particular, the document explains that the availability of accessible medical equipment is an important part of providing accessible medical care, and that health care providers must ensure that medical equipment is not a barrier to individuals with disabilities.[61] The guidance also provides examples of accessible medical equipment, including adjustable-height examination 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 helps ensure clarity to 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

e.g., U.S. Dep't of Health & Human Servs., Admin. for Community Living, *Wheelchair-Accessible Medical Diagnostic Equipment: Cutting Edge Technology, Cost-Effective for Health Care Providers, and Consumer-Friendly, https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/MDE%20Fact%20Sheet%20Final.docx* [*https://perma.cc/GW83-62WW*].

[54] U.S. Dep't of Health & Human Servs., Ctrs. for Disease Control & Prevention, *Disability Impacts All of Us, https://perma.cc/AX9E-9WU3.* The Department also acknowledges that in addition to disability impacting a substantial portion of the population, disability discrimination frequently co-occurs with other types of discrimination.

[55] *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) *https://pubmed.ncbi.nlm.nih.gov/28266148/* [*https://perma.cc/5UBX-WEFE*]; 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.

[56] NCD Report at 15.

[57] *Id.* at 16–17.

[58] *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 examination 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 & Health J. 366, 369 (2019) (stating that of the 462 people who needed a height-adjustable examination table, 56 percent received it).

[59] *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://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://perma.cc/YQG3-ZDZC*].

[60] *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/resources/medical-care-mobility/* [*https://perma.cc/UH8Y-NZWL*].

[61] *Id.*

may be for those who lack adequate access to medical care and treatment. As a 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 ensuring access to health care services through accessible MDE is necessary to provide equitable medical care.[62] As a result of its findings, NCD called upon the Department to revise its ADA regulation to formally adopt the MDE Standards.[63]

By issuing this final rule, the Department is revising its ADA regulation to help ensure that vital health care services, programs, and activities are equally available to individuals with disabilities. Specifically, the Department is adopting and incorporating into its title II ADA regulation the specific technical requirements for accessible MDE that are set forth in the Access Board's MDE Standards.[64]

III. Regulatory Process Matters

The Department has examined the likely economic and other effects of this rule addressing the accessibility of MDE under applicable Executive orders,[65] Federal administrative statutes (*e.g.,* the Regulatory Flexibility Act,[66] Paperwork Reduction Act,[67] and Unfunded Mandates Reform Act [68]), and other regulatory guidance.[69]

As discussed previously, the purpose of this rule is to revise the regulation implementing title II of the ADA in order to ensure that the services, programs, and activities offered by State and local government entities through or with the use of MDE are accessible to people with disabilities. The Department is adopting specific technical standards and scoping requirements related to the accessibility of MDE. This rule is necessary to help public entities understand how to ensure that people with disabilities have equal access to the services, programs, and activities public entities provide through or with the use of MDE.

The Department has carefully crafted this final rule to better ensure compliance with the protections of title II of the ADA, while at the same time doing so in an economically efficient manner. After reviewing the Department's assessment of the likely costs of this regulation, the Office of Management and Budget (''OMB'') has determined that it is a significant regulatory action within the meaning of Executive Order 12866, as amended. As such, the Department has undertaken a Final Regulatory Impact Analysis (''FRIA'') pursuant to Executive Orders 12866 and 14094. The Department has also undertaken a Final Regulatory Flexibility Analysis (''FRFA'') as specified in section 603(a) of the RFA. The results of these analyses are summarized below. In addition, the Department has determined that this rule complies with the requirements of the National Technology Transfer and Advancement Act of 1995 (''NTTAA''), Public Law 104–113, sec. 12(d), 110 Stat. 783, and with the Department's plain language policies. Lastly, the Department does not believe that this regulation will have any impact—significant or otherwise—relative to the federalism principles outlined in Executive Order 13132, the Paperwork Reduction Act, or the Unfunded Mandates Reform Act.

A. Final Regulatory Impact Analysis (''FRIA'') Summary and Final Regulatory Flexibility Analysis (''FRFA'') Summary

1. FRIA Summary

The Department prepared a FRIA for this rulemaking. The Department contracted with Eastern Research Group Inc. (''ERG'') to prepare this economic assessment. This summary of the FRIA provides an overview of the Department's final economic analysis and key findings. The full FRIA will be made available at *www.ada.gov/assets/pdfs/mde-fria.pdf.*

The Department estimates that this title II ADA regulation will affect 6,911 public entities.[70] The Department quantifies incremental costs that affected entities may incur in (1) purchasing or leasing accessible MDE and (2) ensuring qualified staff. The Department also quantifies incremental benefits that people with mobility disabilities may enjoy due to higher shares of accessible MDE, which may yield improved health outcomes. In addition, the Department discusses other benefits flowing from the final rule that cannot be quantified due to lack of data or other methodological reasons.

Table 1 summarizes findings of the economic impact analysis of the likely incremental monetized costs and benefits of the final 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 FINAL RULE OVER A 10-YEAR PERIOD

[In millions of 2023 dollars]

Quantity	Discount rate (3 percent)	Discount rate (7 percent)
Monetized Incremental Costs	$40.3	$40.7
Monetized Incremental Benefits	9.0	5.3

Regarding costs, the Department finds that the final rule would result in annualized costs over a 10-year period of $40.3 million or $40.7 million, corresponding to a 3 or 7 percent discount rate.[71] These costs include

[62] NCD Report at 14.

[63] *Id.* at 52.

[64] As explained in the section-by-section analysis of § 35.104 in the appendix to this rule, the Department is declining to adopt the two sunset provisions in the January 9, 2017, version of the Access Board's MDE Standards. Other than those two provisions, the Department is adopting the January 9, 2017, version of the Access Board's MDE Standards, as contained in 82 FR 2845 through 2848, in full.

[65] *See* E.O. 13563, 76 FR 3821 (Jan. 18, 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 (Sept. 30, 1993), as amended by E.O. 14094, 88 FR 21879 (Apr. 6, 2023).

[66] Regulatory Flexibility Act of 1980 (''RFA''), as amended by the Small Business Regulatory Enforcement Fairness Act of 1996, 5 U.S.C. 601 *et seq.*

[67] Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.*

[68] Unfunded Mandates Reform Act of 1995, 2 U.S.C. 1501 *et seq.*

[69] *See* Office of Mgmt. & Budget, *Circular A–4* (Sept. 17, 2003) (superseded by Office of Mgmt. & Budget, *Circular A–4* (Nov. 9, 2023)).

[70] The estimate of 6,911 public entities comes from HHS and the Centers for Medicare & Medicaid Services, based on information in the U.S. Census Bureau's 2019 Statistics of U.S. Businesses Annual Data Table by Establishment Industry, U.S. & States, 6-digit NAICS. *See* Table 2 of the FRIA for more information.

[71] *See* Table 11 of the FRIA for derivation of this estimate.

incremental costs that affected entities may incur in purchasing or leasing accessible MDE and ensuring qualified staff. All values are presented in 2023 dollars, as 2024 data were not yet available at the time this analysis was performed.

Regarding benefits, the FRIA finds that the final rule would result in annualized benefits over a 10-year period of $9.0 million at a 3 percent discount rate or $5.3 million at a 7 percent discount rate. Monetized benefits are based on an assessment of reduced mortality and morbidity risks from cancer diagnoses for individuals with mobility disabilities.

In addition to providing a monetized benefit estimate, the FRIA discusses potentially enormous unquantified benefits under the rule. The Department expects that the rule will result in myriad benefits for individuals with mobility disabilities flowing from greater access to health care, such as the benefits of accurate drug dosing for persons with disabilities who will now be able to be weighed and given proper drug regimens due to accessible weight scales. Other unquantified benefits include increased equality, dignity, and the prevention of frustration, embarrassment, and harms to self-esteem.

As further discussed in section 2.d of the FRIA, all public entities in the health care sector likely 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 noted above, title II and section 504 impose parallel requirements, and courts have interpreted them to be consistent. Maintaining that consistency, this rule under title II imposes virtually the same obligations on public entities as HHS's rule imposes under section 504. If this rule did not adopt the MDE Standards and otherwise parallel the requirements set forth in HHS's section 504 rule, courts might interpret title II to impose obligations on public entities that differ from those under section 504, resulting in confusion, uncertainty, duplication, litigation, and increased compliance costs for the many entities covered by both statutes. The adoption of this rule under title II, which parallels the MDE provisions of HHS's section 504 rule, avoids these pitfalls.

2. FRFA Summary

The Department examined the impact of the rule on small entities as required by the RFA. In the NPRM, the Department certified that the proposed rule would not have a significant economic impact on a substantial number of small entities.[72] The Department sought public comment on this certification and its underlying analysis, including the costs to small entities. A few commenters stated that the costs of complying with this rule would be much higher than the Department estimated, particularly for small entities. However, these comments made only general statements and provided no data to adjust the costs. Commenters provided no specific information that would call into question the validity of the data and methods used to calculate costs both for government entities in general and small government entities in particular.

The Department has prepared a FRFA to comply with its obligations under the RFA. The FRFA will be published along with the Department's FRIA, and it will be made available to the public at *www.ada.gov/assets/pdfs/mde-fria.pdf.* The FRFA describes and estimates the number of small entities to which this rule applies and estimates the economic impacts on small entities. The FRFA examines which industry groups would be financially impacted the most by this rule. The FRFA also explains the assumptions on which it is based and explains the criteria used to assess what constitute ''significant economic impacts'' and ''a substantial number'' of small entities. Based on this analysis, the Attorney General has again reviewed this regulation in accordance with the RFA, 5 U.S.C. 605(b), and certifies that the rule will not have a significant economic impact on a substantial number of small entities.

B. Executive Order 13132: Federalism

Executive Order 13132 requires executive branch agencies to consider whether a rule will have federalism implications.[73] 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 rule is likely to have federalism implications, it must consult with State and local government officials about how to minimize or eliminate those effects.

Title II of the ADA covers State and local government services, programs, and activities, and therefore clearly has some federalism implications. State and local governments have been subject to the ADA since 1991, and the many State and local government entities that receive Federal financial assistance have also been required to comply with the requirements of section 504. Hence, neither the ADA nor the title II regulation is novel for State and local governments.

In crafting this regulation, the Department has been mindful of its obligation to meet the objectives of the ADA while also minimizing conflicts between State law and Federal interests, consistent with section 4(c) of Executive Order 13132. The Department sought public comment in the NPRM on the potential federalism implications of this rule, including whether the 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. The Department received no comments from State or local governments on this issue.

The Department clarifies that, consistent with 42 U.S.C. 12201(b), this rule preempts 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 rule does not invalidate or limit the remedies, rights, or procedures of any State laws that provide greater or equal protection for the rights of individuals with disabilities. Moreover, the Department's provision on equivalent facilitation at § 35.211(d) provides that nothing in these requirements prevents the use of designs, products, or technologies as alternatives to those prescribed by the MDE Standards, provided they result in substantially equivalent or greater accessibility and usability of the health care service, program, or activity. Accordingly, for example, if a State law required public entities in that State to comply with a different standard than the MDE Standards, nothing in this rule would prevent a public entity from complying with the different standard if the use of that standard resulted in substantially equivalent or greater accessibility and usability of the public entity's health care service, program, or activity. Responsibility for demonstrating equivalent facilitation rests with the public entity.

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

[72] *See* 89 FR 2193.

[73] 64 FR 43255 (Aug. 4, 1999).

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.[74] 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.[75]

The Department is adopting the MDE Standards issued by the Access Board as the accessibility standard to apply to the services, programs, and activities that State and local governments offer using MDE.[76] As discussed in section II.C, the MDE Standards were adopted by the Access Board, an independent Federal agency that includes public members and holds regular public meetings, in 2017 after a five-year review period. The review 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. These standards were developed as required by section 510, as amended, and were developed in consultation with the Food and Drug Administration. 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 the MDE Standards for this rule.

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) 610–1264 (TTY) that the public is welcome to call to get assistance understanding anything in this rule. In addition, the ADA.gov website provides information in plain language about the ADA and the Department's ADA rules, including this final rule.

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.[77] This final 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 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.'' [78] Accordingly, this rulemaking is not subject to the provisions of the Unfunded Mandates Reform Act.

G. Congressional Review Act

This regulation is not a major rule as defined by the Congressional Review Act, 5 U.S.C. 801 *et seq.*

List of Subjects for 28 CFR Part 35

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

By the authority vested in me as Attorney General by law, including 5 U.S.C. 301; 28 U.S.C. 509, 510; sections 201 and 204 of the Americans with Disabilities Act, Public Law 101–336, as amended, and section 506 of the ADA Amendments Act of 2008, Public Law 110–325, and for the reasons set forth in appendix E to 28 CFR part 35, chapter I of title 28 of the Code of Federal Regulations is 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 definitions of ''Medical diagnostic equipment'' and ''Standards for Accessible Medical Diagnostic Equipment'' in alphabetical order to read as follows:

§ 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 promulgated by the Architectural and Transportation Barriers Compliance Board under section 510 of the Rehabilitation Act of 1973, as amended, found at 36 CFR part 1195 (revised as of July 1, 2017), with the exception of M301.2.2 and M302.2.2.

* * * * *

■ 3. Add subpart I to read as follows:

Subpart I—Accessible Medical Diagnostic Equipment

Sec.

§ 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.

[74] Public Law 104–113, sec. 12(d)(1); *see also* Office of Mgmt. & Budget, *Circular A–119* (Jan 27, 2016), *https://www.whitehouse.gov/wp-content/uploads/2020/07/revised_circular_a-119_as_of_1_22.pdf* [*https://perma.cc/A5LP-X3DB*].

[75] Public Law 104–113, sec. 12(d)(2).

[76] As explained in the analysis and response to public comments regarding § 35.104 in the appendix to this rule, the Department is not adopting the sunset provisions at M301.2.2 and M302.2.2.

[77] 44 U.S.C. 3501 *et seq.*

[78] 2 U.S.C. 1503(2).

§ 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 (including via lease renewals), or otherwise acquire after October 8, 2024, 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 August 9, 2024, 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 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 this section 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) of this section 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 (f) 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 (a) 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 this paragraph (a) 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 this paragraph (a) would result in a fundamental alteration under paragraph (a)(2) of this section if it demonstrates that compliance with this paragraph (a) 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]

■ 4. Add appendix E to part 35 to read as follows:

Appendix E to Part 35—Guidance to Revisions to ADA Title II Regulation on Accessibility of Medical Diagnostic Equipment of State and Local Government Entities

Note: This appendix contains guidance providing a section-by-section analysis of the revisions to this part published on August 9, 2024.

Section-by-Section Analysis and Response to Public Comments

This appendix provides a detailed description of the Department's changes to this part (the title II regulation), the reasoning behind those changes, and responses to significant public comments received in connection with the rulemaking. The Department made changes to subpart A of this part and added subpart I to this part. The section-by-section analysis addresses the changes in the order they appear in the title II regulation.

Subpart A—General

Section 35.104 Definitions

The Department is revising § 35.104 to add definitions for the terms ''medical diagnostic equipment'' and ''Standards for Accessible Medical Diagnostic Equipment.''

Medical Diagnostic Equipment

The Department is defining the term ''medical diagnostic equipment,'' consistent 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 requires the MDE Standards to set forth the minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physicians' offices, clinics, emergency rooms, hospitals, and other medical settings, and also requires the MDE Standards to 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 some types of MDE but are not exhaustive. The Department received one comment recommending that the Department specifically require that diagnostic equipment used by optometrists and ophthalmologists be accessible. The regulatory text explains that MDE includes examination chairs used for eye examinations or procedures, but the Department cannot and need not provide an exhaustive list of all medical specialties whose equipment is covered by subpart I of this part. Equipment is covered by subpart I if health care providers use it in, or in conjunction with, medical settings for diagnostic purposes.

The Department received several comments requesting clarification on whether the definition of ''medical diagnostic equipment'' applies to equipment used outside of a medical facility, such as in home settings, mobile health clinics, or through telehealth appointments or remote diagnostic assessments. Some commenters recommend that the Department explicitly state that the definition of ''medical diagnostic equipment'' extends to equipment used in such settings.

MDE is ''[e]quipment used in, or in conjunction with, medical settings by health care providers for diagnostic purposes,'' and the obligations set forth in subpart I of this part apply to ''service[s], program[s], or activit[ies] offered through or with the use of MDE,'' subject to the limitations described in subpart I. Whether a public entity needs to ensure that a specific piece of equipment used in the provision of health care services, programs, or activities in home or other settings complies with the MDE Standards would depend on the particular factual circumstances in question.

Standards for Accessible Medical Diagnostic Equipment

The Department is defining the term ''Standards for Accessible Medical Diagnostic Equipment'' in accordance with the standards promulgated by the Access Board on January 9, 2017, under section 510 of the Rehabilitation Act of 1973, as amended, and codified on July 1, 2017, found at 36 CFR part 1195 (revised as of July 1, 2017). That is the version of the Access Board's MDE Standards that was in effect when the Department issued its notice of proposed rulemaking (NPRM).[1] The Department is not, however, adopting two provisions that were included in the January 9, 2017, version of the Access Board's standards, M301.2.2 and M302.2.2 (''the sunset provisions''). The sunset provisions stated that the 17-inch to 19-inch low transfer height range set forth in M301.2.1 and M302.2.1 would cease to have effect on January 10, 2022.[2] Accordingly, if the definition of the MDE Standards that the Department is adopting did not exclude the sunset provisions, there would be no enforceable minimum low transfer height standard, since this final rule is being promulgated after January 10, 2022. By adopting the January 9, 2017, version of the MDE Standards that was codified on July 1, 2017, but excluding the sunset provisions, the Department is adopting and making enforceable the 17-inch to 19-inch low transfer height range set forth in M301.2.1 and M302.2.1 of the January 9, 2017, version of the MDE Standards. Under the final rule, public entities acquiring accessible MDE have the option of acquiring MDE that lowers to between 17 inches and 19 inches. However, under § 35.212(a), public entities are required to operate their services, programs, and activities that use MDE so that they are readily accessible to and usable by individuals with disabilities, regardless of whether the entities' MDE lowers to 17 inches or 19 inches.

Several commenters submitted comments on the low transfer height requirement. One commenter recommended that the Department make the temporary low transfer height range a permanent requirement. Some commenters expressed concern about the feasibility of complying with a 17-inch low transfer height standard, and several other commenters said the Department should adopt a 17-inch low transfer height standard in anticipation of the Access Board finalizing a 17-inch standard. As noted in the previous paragraph, the Department is adopting the 17-inch to 19-inch low transfer height range, without adopting the sunset provisions. The Department believes it is appropriate to adopt the MDE Standards promulgated by the Access Board, which were the product of a multi-year deliberative process. As to the comments supporting or opposing a 17-inch low transfer height standard, the Access Board had not yet issued a final rule establishing a 17-inch low transfer height standard when the Department issued its NPRM. Therefore, it would have been premature for the Department to have sought public comment on or proposed adopting the 17-inch standard in the NPRM, and the Department declines to adopt and make enforceable such a standard in the final rule without public comment. As noted in section II.C of the preamble to the final rule, however, since the Access Board has now issued a final rule updating the low transfer height standard, the Department will consider issuing a supplemental rulemaking under title II proposing to adopt it, and the Department will solicit comments on the updated standard as part of any such rulemaking.

Some commenters urged the Department to work with the Access Board to account for the needs of particular disability groups more explicitly. Commenters asked that the Department consider more specifically the needs of individuals with nonmobility disabilities, people with respiratory disabilities, people who are blind or have other sensory disabilities, higher weight people, and people with intellectual disabilities. The MDE Standards account for the needs of individuals with nonmobility

[1] Although HHS's final rule addressing the accessibility of medical diagnostic equipment under section 504 contains a different citation in its definition of the term *Standards for Accessible Medical Diagnostic Equipment, see* 89 FR 40184, that difference is the result of citation formatting conventions of the Office of the Federal Register. There is no substantive difference between the definition of the term *Standards for Accessible Medical Diagnostic Equipment* adopted in HHS's final rule and the definition of that term adopted in DOJ's final rule.

[2] 36 CFR part 1195, appendix, section M301.2.2 (stating that M301.2.1 and M302.2.1 would cease to have effect on January 10, 2022).

disabilities to some extent,[3] and any new standards to account for additional disabilities or factors that the Access Board did not incorporate into the MDE Standards should be developed by the Access Board, which has authority to promulgate such standards under section 510. The Department notes that the Access Board received comments recommending that the MDE Standards address ''individuals with autism, Alzheimer's, sensory disabilities, cognitive disabilities, and bariatric patients,'' and noted that while it could not accommodate those comments in this round of rulemaking, it committed to ''address[ing] other barriers in future updates to the MDE Standards.'' [4] Therefore, while the Department appreciates commenters' viewpoints, it declines to update this part to account for additional disabilities or factors at this time.

The Department also received many comments from diverse stakeholders on whether the Department should apply the Access Board's MDE Standards to medical equipment that is not used for diagnostic purposes. Many commenters supported applying the MDE Standards to nondiagnostic medical equipment, especially equipment used for therapeutic or treatment purposes. Other commenters urged the Department not to expand the requirements beyond MDE at this time. Some commenters also stated that the Department lacks technical expertise to unilaterally impose technical standards on a broad range of nondiagnostic medical equipment. One commenter recommended that if the Department adopts enforceable standards regarding the accessibility of nondiagnostic medical equipment, the Department should first explain its proposed approach in detail to allow for additional public input on the types of nondiagnostic medical equipment to which those standards would apply.

The Department agrees that any extension of the MDE Standards to nondiagnostic medical equipment, or the adoption of any new standards for nondiagnostic medical equipment, should be informed by the Access Board's extensive knowledge and technical acumen, as well as by additional public input. If, in the future, the Department adopts enforceable technical standards concerning the accessibility of nondiagnostic medical equipment, it will consult with the Access Board and other Federal partners and make clear to covered entities what types of equipment will be required to meet those standards. But because the Access Board has not developed specific technical standards regarding the accessibility of nondiagnostic medical equipment, and given the need to provide public entities with clarity about the scope of any standards the Department is adopting, the Department declines to adopt enforceable technical standards for nondiagnostic medical equipment or otherwise extend the Access Board's standards at this time.

The Access Board's standards apply only to equipment that is used in, or in conjunction with, medical settings by health care providers for diagnostic purposes. As noted in the NPRM, equipment used for both diagnostic purposes and other purposes (such as therapeutic or treatment purposes) is MDE if it otherwise meets this definition, and must therefore meet the requirements for accessible MDE set forth in subpart I of this part. The Department will continue to consider whether to conduct further rulemaking in the future.

Several commenters emphasized the importance of accessibility in the provision of health care services that use medical equipment, whether that equipment is used for diagnostic purposes or not. The Department clarifies that public entities are already obligated to ensure that their services, programs, and activities do not exclude or discriminate against individuals with disabilities and are readily accessible to and usable by individuals with disabilities.[5] This obligation encompasses the provision of health care services by public entities, whether those services use MDE or not.

Subpart I—Accessible Medical Diagnostic Equipment

The Department is creating a new subpart in its title II regulation. Subpart I of this part addresses the accessibility of public entities' medical diagnostic equipment.

Section 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 provider also cannot require a patient with a disability to bring someone along with them to help during an examination if similar requirements are not imposed on patients without disabilities. A patient may choose to bring another person such as a friend, family member, or personal care aide to an appointment, but regardless, the provider may need to provide reasonable assistance to enable the patient to receive medical care.[6] Such assistance may include, for example, helping a person who uses a wheelchair to transfer from their wheelchair to the examination table or diagnostic chair.[7] The provider cannot require the person accompanying the patient to assist.

Individuals and groups, including disability advocacy organizations, individuals with disabilities and their family members, health care providers and associations, and manufacturers of medical equipment, submitted comments on the Department's proposed rule. Overwhelmingly, the commenters expressed strong support for adopting the MDE Standards and requiring public entities to ensure that their services, programs, and activities offered through or with the use of MDE are accessible to individuals with disabilities.

Many commenters described the importance of accessible MDE and provided firsthand accounts of instances when they or their family members were unable to receive health care or received substandard health care because providers lacked accessible examination tables, weight scales, or radiological or other diagnostic equipment. Several commenters recounted instances when they or their family members were unable to receive preventative health care services such as mammograms, prostate examinations, or dental examinations. Other commenters noted that they could not have their weight checked regularly because of the lack of accessible weight scales, resulting in health care risks such as a failure to provide the amount of medication required. Some commenters described entities' expectations that individuals with mobility disabilities would be accompanied by companions to physically transfer them onto MDE. Disability advocacy groups also shared representative accounts submitted by their members, documenting the harms experienced by people with disabilities due to health care providers' lack of accessible MDE.

The Department agrees with commenters that accessible MDE is vital for health equity, person-centered care, and access to medical care for patients with disabilities. As discussed in the NPRM, research has documented that the scarcity of accessible MDE constitutes a significant barrier to access to care for patients with disabilities, resulting in a failure to provide adequate preventative health care and diagnostic examinations.[8]

As explained in more detail in the NPRM, the Department is aware of many instances in which people with disabilities were denied access to needed care, were subjected to demeaning situations, or received substandard care because health care providers lacked accessible MDE.[9] The Department has taken action to enforce the ADA as it applies to the provision of health care services.[10] However, the lack of technical standards for accessible MDE before the Access Board issued the MDE Standards in 2017, and the fact that, until now, the MDE Standards were not enforceable under title II, mean that these circumstances remain all too prevalent. Section 35.210 will help clarify public entities' nondiscrimination obligations as

[3] *See, e.g.,* 36 CFR part 1195, appendix (revised as of July 1, 2017) (discussing, in M306, requirements for communication necessary for performance of a diagnostic procedure).

[4] *Id.* at 2812.

[5] *See, e.g.,* §§ 35.130 and 35.150.

[6] *See id.* § 35.130(b)(7).

[7] *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/resources/medical-care-mobility/* [*https://perma.cc/UH8Y-NZWL*].

[8] 89 FR 2186.

[9] *Id.*

[10] *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://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://perma.cc/YQG3-ZDZC*].

they pertain to services, programs, and activities that use MDE.

Section 35.211 Newly Purchased, Leased, or Otherwise Acquired Medical Diagnostic Equipment

For MDE that public entities purchase, lease, or otherwise acquire after October 8, 2024, which is 60 days after the publication of the final rule in the **Federal Register**, the Department is adopting an approach that draws on the approach that the existing title II regulation applies to new construction and alterations of buildings and facilities.[11] Section 35.211(a) requires that all MDE that a public entity purchases, leases, or otherwise acquires more than 60 days after publication must be accessible, unless and until the scoping requirements set forth in more detail in § 35.211(b) are satisfied.

As in the fixed or built environment, the accessibility of MDE is 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, the public entity is not required to continue to obtain accessible MDE when it purchases, leases, or otherwise acquires MDE after the final rule's effective date. However, a public entity may choose to acquire additional accessible MDE even after it satisfies the scoping requirements.

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

Paragraph (a) adopts the January 9, 2017, version of the Access Board's MDE Standards that was codified on July 1, 2017 (with the exception of the Access Board's sunset provisions, as explained in the section-by-section analysis of the definition of the term ''Standards for Accessible Medical Diagnostic Equipment'' in § 35.104), as the standard governing whether MDE is accessible, and establishes one of the key requirements of subpart I of this part: that subject to applicable limitations and defenses, all MDE that public entities purchase, lease, or otherwise acquire more than 60 days after the publication of the final rule must meet the MDE Standards unless and until the public entity already has a sufficient amount of accessible MDE to satisfy the scoping requirements in § 35.211(b).

As explained in more detail in section II.C of the preamble to the final rule (''Overview of Access Board's MDE Standards''), the MDE Standards include technical criteria for equipment that is used when patients are (1) in a supine, prone, or side-lying position; (2) in a seated 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 contain requirements for equipment to be compatible with patient lifts where a patient would transfer under positions (1) and (2).

Consistent with the language in 29 U.S.C. 794f(b), MDE covered under subpart I of this part 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. As noted in the section-by-section analysis of § 35.104, subpart I of this part 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 public entities' health care services, programs, and activities.

In the NPRM, the Department sought comment on whether 60 days is an appropriate amount of time for these requirements to take effect. A number of commenters said 60 days is the right amount of time, including one commenter who recommended no more than 60 days and another who recommended no less than 60 days. However, a few commenters thought 60 days would not be enough time to comply with these requirements. Those commenters expressed concern that it could be difficult for public entities to obtain accessible MDE and carry out this section's requirements within 60 days, and that a 60-day requirement would be too burdensome for small or under-resourced public entities in particular. One commenter said 60 days is the right amount of time for MDE that does not require construction, but that a longer timeframe should apply to MDE that necessitates construction in the room in which the MDE will be located, such as magnetic resonance imaging (''MRI'') scanners. One commenter recommended 180 days, not 60 days, to give public entities time to carry out this section's requirements, and asked the Department to clarify whether public entities will be expected to comply with the scoping requirements set forth in § 35.211(b) upon the effective date of the final rule or later. The commenter recommended that public entities be given at least two years from the final rule's publication date to achieve compliance with the scoping requirements.

The Department agrees with the majority of commenters who commented on this issue and concludes that 60 days is the appropriate amount of time for the requirements set forth in § 35.211(a) to take effect because it strikes an appropriate balance between the immediate and urgent health care needs of individuals with disabilities and the constraints facing public entities. Therefore, all MDE that public entities acquire more than 60 days after publication shall meet the MDE Standards, unless and until the scoping requirements in § 35.211(b) are met. In response to the commenters who are concerned that a 60-day time period will be too burdensome, the Department notes that public entities are not required to take steps that would result in an undue burden or a fundamental alteration, as set forth in more detail in § 35.211(e). The Department also notes that public entities have been on notice since the NPRM was issued in January 2024 that the Department was considering imposing this requirement, giving them time to prepare to carry out the requirements of subpart I of this part.

The Department also clarifies that, once it takes effect 60 days after publication, § 35.211(a) will only require MDE to meet the MDE Standards if it is acquired after the effective date (subject to the scoping requirements and the other requirements and limitations of subpart I of this part). That means, for example, that if a public entity does not acquire any MDE until 180 days after publication, the MDE that the entity acquires 180 days after publication will be required to meet the MDE Standards (assuming the entity has not already met the scoping requirements and no limitations apply), but the entity's existing MDE will not be required to meet the MDE Standards. In other words, although the timeframe set forth in § 35.211(a) is 60 days after publication, the question of when a particular public entity's MDE will be required to meet the MDE Standards will depend on when the entity acquires MDE after publication, which could be more than 60 days after publication. This reinforces the Department's conclusion that 60 days is the appropriate amount of time for § 35.211(a) to take effect.

The Department also clarifies that to ''purchase, lease, or otherwise acquire'' MDE more than 60 days after publication means to acquire MDE by any means. A few commenters requested that the Department make clear that leases include lease renewals, and that acquisitions include acquisitions in any form, including, but not limited to, acquisitions via gifts or loans, as well as both temporary and permanent acquisitions. To avoid any confusion, the Department is clarifying in the § 35.211(a) regulatory text that the term ''lease'' includes the renewal of existing leases. The Department's intent is that the term ''lease'' includes lease renewals, and it is modifying the § 35.211(a) regulatory text to avoid any confusion. The Department also agrees with commenters that to ''purchase, lease, or otherwise acquire'' MDE in the context of subpart I of this part means to acquire MDE through any means, including, but not limited to, acquisitions via donations or loans, as well as both temporary and permanent acquisitions. This intent is reflected by the term ''otherwise acquire'' in the regulatory text.

Section 35.211(b) Scoping

Section 35.211(b) establishes 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.[12] The MDE Standards issued by the Access Board

[11] *See generally* § 35.151.

[12] *See* 36 CFR part 1191, appendix B, section 213.3.1.

contain technical requirements, but they do not specify scoping requirements. Rather, they state that ''[t]he enforcing authority shall specify the number and type of diagnostic equipment that are required to comply with the MDE Standards.'' [13] 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.

Paragraphs (b)(1) through (3) of § 35.211 lay out scoping requirements for this section. The scoping requirements that the Department is establishing 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.[14] Because public entities must comply with title II of the ADA, many public entities are likely already familiar with these standards.

The Department drew on the following approaches from the 2010 ADA Standards in formulating the scoping requirements for the final rule. 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.[15] 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.[16] 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 sleeping room, provide specific accessibility features for patients with mobility disabilities.[17] 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.[18] 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.[19] Several of these approaches are reflected in the scoping requirements adopted in paragraph (b) of § 35.211 for MDE.

Paragraph (b)(1) of § 35.211 provides the general requirement for physicians' 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 must have 2 examination chairs (10 percent of the total) that comply with the MDE Standards. In a medical practice with five examination chairs, the practice must 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 must be accessible. However, these requirements do not apply until an entity newly acquires MDE, as explained in the section-by-section analysis of § 35.211(a).

Paragraph (b)(2) of § 35.211 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 be required 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. As with paragraph (b)(1), the scoping requirements of paragraph (b)(2) do not apply until an entity newly acquires MDE.

The Department received many comments on the scoping percentages in § 35.211(b)(1) and (2). Many commenters acknowledged the need to provide accessible MDE and supported the inclusion of scoping requirements. Some commenters expressed concern that the scoping requirements could have a profound financial and operational impact on small hospitals, potentially leading to reduced availability of essential diagnostic services in rural and underserved areas; expressed concern about the amount of accessible MDE currently available on the market; or requested more time to acquire MDE that meets the MDE Standards and resources to help health care providers comply. Many other commenters, including disability advocates and disability rights organizations, voiced concerns that the scoping provisions are too low to meet demand among people with mobility disabilities. Without a requirement that a larger percentage of MDE or 100 percent of MDE be accessible, they asserted that patients with disabilities will have fewer scheduling options or longer wait times than nondisabled patients. One commenter also stated that it would be simpler and clearer to require all newly acquired MDE to be accessible. Another commenter noted that while it would be ideal for all MDE to be accessible, this would place an undue burden on health care providers, and the needs of individuals with disabilities can be fully addressed if health care providers have some accessible MDE and engage in proper planning to prevent delays and denials in the delivery of health care services.

Many of the commenters who viewed the scoping requirements as too low objected to modeling the scoping requirements 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. Those commenters cited factors such as the prevalence of disability; the belief that accessible MDE is more in demand than accessible parking spaces; and the fact that, unlike accessible parking spaces, accessible MDE can also be used by nondisabled individuals. Some commenters suggested instead modeling the scoping requirements on the ''replacement rule'' that applies to transportation services under title II, which requires that all newly purchased and leased vehicles be readily accessible to and usable by people with disabilities.[20] Other commenters suggested different approaches, such as imposing higher scoping requirements for MDE that is used to provide preventive services outlined by the U.S. Preventive Services Task Force, or imposing higher scoping requirements for MDE that is used more frequently.

While several commenters opposed having different scoping requirements in § 35.211(b)(1) and (2), others supported the approach of imposing a higher scoping requirement in § 35.211(b)(2) (for facilities that specialize in treating conditions that affect mobility) than in § 35.211(b)(1) (for other facilities). Other commenters noted the importance of considering the department and type of facility in formulating the scoping requirements.

The Department appreciates all of the comments on the scoping requirements in § 35.211(b). The Department acknowledges the concerns of commenters who believe health care providers might have difficulty complying with the scoping requirements, as well as the countervailing concerns of commenters seeking more stringent scoping requirements. As discussed in section III.A.2 of the preamble to the final rule, the Department certifies that the final rule will not have a significant impact on a substantial number of small entities. While the Department appreciates that the final rule may result in increased demand for accessible MDE, commenters did not submit data to suggest that the market cannot bear the additional demand. In any case, if equipment that meets the MDE Standards is unavailable, the fundamental alteration or undue burdens limitations may apply, as explained in § 35.211(e).

The Department recognizes that there are many potential models on which it could base its scoping requirements and

[13] 36 CFR part 1195, appendix, section M201 (revised as of July 1, 2017).

[14] *See* 36 CFR part 1191, appendix B, sections 208.2.2, 223.2.1, 223.2.2.

[15] *See* § 35.151(h); 36 CFR part 1191, appendix B, section 223.1.

[16] *See* 36 CFR part 1191, appendix B, section 223.1.1.

[17] *See id.* section 223.2.1.

[18] *See id.* section 223.2.2.

[19] *See id.* section 208.2.2.

[20] *See* 49 CFR part 37, subpart D.

acknowledges that the needs underlying the accessible parking model are not perfectly aligned with the needs underpinning accessible MDE. However, the Department continues to believe that the use of MDE is analogous to the use of parking spaces at rehabilitation facilities because, as with parking spaces, several different patients with mobility disabilities can use the same piece of MDE in a day.

As explained in the NPRM, 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, which requires that 100 percent of patient sleeping rooms in similar facilities provide specific accessibility features for patients with mobility disabilities. The Department concluded that the time-limited use of MDE is more analogous to the use of parking spaces at a rehabilitation facility than to the use of sleeping rooms because, unlike MDE, sleeping rooms are generally occupied for all or a significant part of the day. Thus, § 35.211(b) draws on the 2010 ADA Standards' scoping requirements by requiring, in § 35.211(b)(1), 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, in § 35.211(b)(2), 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. Imposing higher scoping requirements for facilities that specialize in the treatment of conditions that affect mobility has proven to be a workable framework in the context of the 2010 ADA Standards' scoping requirements, and the Department believes this will also be a helpful framework for the MDE scoping requirements.

In view of demands on provider entities,[21] the Department will not increase the scoping requirements beyond 10 percent for § 35.211(b)(1) and 20 percent for § 35.211(b)(2) at this time. The Department does not agree with several commenters who opined that the use of MDE is analogous to the use of vehicles covered by the ADA title II transportation accessibility requirements. MDE often cannot be retrofitted to be accessible with the same ease or cost ratio as transportation retrofits. For example, inaccessible weight scales typically do not have large platforms that are required for wheelchair access. Inaccessible examination tables are usually fixed height ''box'' tables with static bases, and possibly drawers, that cannot easily be replaced with adjustable mechanisms.[22] The Department therefore declines to adopt an approach akin to the ''replacement rule'' that applies in the title II transportation accessibility context, which would require that 100 percent of newly acquired MDE be accessible.[23] And although one commenter suggested relying on the U.S. Preventive Services Task Force recommendations, the Department does not believe that these recommendations would serve as a useful basis for the scoping requirements in § 35.211(b). The U.S. Preventive Services Task Force makes evidence-based recommendations on clinical preventive services and health promotion in primary care settings,[24] but those recommendations are not primarily about the use of MDE and therefore do not serve as a useful model for scoping requirements related to MDE.

The Department also does not believe it is necessary to impose higher scoping requirements for MDE that is used more frequently than other types of MDE, as some commenters suggested. Providers are likely to have more units of the types of MDE that are used more frequently, and the more units of MDE a provider has, the more units will need to be accessible according to the scoping requirements.

The Department therefore will not increase the scoping requirements set forth in § 35.211(b) at this time or eliminate the distinction between the general scoping requirements in § 35.211(b)(1) and the scoping requirements for facilities that specialize in treating conditions that affect mobility in § 35.211(b)(2). The Department notes that, because paragraph (b) requires that at least one unit of each type of MDE in use meet the MDE Standards irrespective of the percentage requirements, some smaller health care providers will be required to have a proportion of accessible MDE that exceeds 10 percent for paragraph (b)(1) or 20 percent for paragraph (b)(2). For example, barring an applicable limitation or defense, a provider with two dental chairs will be required to have at least one dental chair that meets the MDE Standards, which is 50 percent of the provider's total.

The Department also clarifies that the scoping requirements set forth in § 35.211(b) must be read in conjunction with the requirements set forth elsewhere in subpart I of this part. Section 35.210 prohibits public entities from excluding, denying benefits to, or otherwise discriminating against people with disabilities in services, programs, or activities that use MDE, and § 35.212 requires that each service, program, or activity that uses MDE be readily accessible to and usable by people with disabilities in its entirety, independent of the scoping requirements for newly acquired MDE set forth in § 35.211(b). That means, for example, that denying a physical examination to a patient with a disability because of the lack of accessible MDE may violate the nondiscrimination obligation set forth in § 35.210, even if the scoping requirements set forth in § 35.211(b)(1) and (2) have not yet been triggered by the new acquisition of MDE. As another example, if, even after a provider complies with the scoping requirements set forth in § 35.211(b)(1) and (2), patients with disabilities have significantly fewer scheduling options than nondisabled patients, that could implicate the obligation in § 35.212 to make public entities' services, programs, and activities readily accessible to and usable by individuals with disabilities. Public entities may determine that the most effective way to carry out the obligations set forth in §§ 35.210 and 35.212 will be to acquire additional accessible MDE beyond the scoping requirements set forth in § 35.211(b)(1) and (2).

Finally, one commenter requested clarification on whether the required number of units of accessible MDE should be rounded up or down if application of the scoping percentages does not yield a whole number. If application of the scoping percentages yields a number less than one, the number will need to be rounded up to one because § 35.211(b)(1) and (2) require that no fewer than one unit of each type of equipment in use meet the MDE Standards. If application of the scoping percentages yields a number greater than one, the standard mathematics rule on rounding decimals to whole numbers applies to the scoping requirements in § 35.211(b)(1) and (2).[25]

Section 35.211(b)(3) addresses facilities or programs with multiple departments, clinics, or specialties. 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. This dispersion requirement is analogous to the existing title II ADA regulation that requires dispersion of accessible sleeping rooms in medical care facilities that do not specialize in the treatment of conditions that affect mobility.[26]

[21] *See* FRIA at 69–70 (considering the costs of increasing the scoping requirements in § 35.211(b)(1) and (2) to 20 percent and 40 percent respectively, as well as the costs of requiring that 100 percent of newly acquired MDE meet the MDE Standards and concluding that those alternative potential scoping requirements could more than double the annualized costs of the final rule).

[22] ADA Nat'l Network, *Accessible Medical Examination Tables and Chairs* (2017), *https://adata.org/factsheet/accessible-medical-examination-tables-and-chairs [https://perma.cc/Y6MR-9QGL].*

[23] *See* 49 CFR part 37, subpart D.

[24] *See* U.S. Preventive Services Task Force, *About the USPSTF, https://www.uspreventiveservices taskforce.org/uspstf/about-uspstf* [*https://perma.cc/FTL2-TLXX*].

[25] That is, numbers that end in a digit less than five are rounded down to the nearest whole number, and numbers that end in a digit greater than or equal to five are rounded up to the nearest whole number. For example, if a program that did not specialize in treating conditions that affect mobility used four units of MDE, then it would be required to have at least one unit of accessible MDE because, even though 0.4 units (10 percent of four) would be rounded down to zero, the final rule requires that each service, program, or activity have at least one unit of accessible MDE. If there were 12 units of MDE in use, the program would be required to have one unit of accessible MDE because 1.2 (10 percent of 12) is rounded down to one. If there were 15 units of MDE in use, the program would be required to have two units of accessible MDE because 1.5 (10 percent of 15) is rounded up to two.

[26] *See* § 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 all patient sleeping rooms in those facilities are required to be accessible. *See* 36 CFR part 1191, appendix B, section 223.2.2.

Section 35.211(b)(3) does not require that accessible MDE be dispersed with exact mathematical proportionality, which at times would be impossible. Section 35.211(b)(3) also does not require public entities to acquire additional MDE, beyond the amount specified in paragraphs (b)(1) and (2), to ensure that accessible MDE is available in every department, clinic, and specialty. This approach is consistent with many provisions of the 2010 ADA Standards.[27] Additionally, if § 35.211(b)(3) were to require full dispersion across every department, clinic, and specialty, it could create inconsistency or confusion between the dispersion and scoping requirements. For example, if a health care program that operated out of three clinics was required to have two units of accessible MDE according to the scoping provisions, then if paragraph (b)(3) required public entities to disperse their accessible MDE across every department, clinic, and specialty, the entity could meet the scoping requirements but would nonetheless violate the dispersion requirements because the two units of accessible MDE that the scoping provision required would not be enough to fully disperse across all three clinics. If paragraph (b)(3) required public entities to disperse fully across every department, clinic, and specialty, it could also be difficult to determine whether more precise dispersion requirements had been met. For example, a clinic may be part of a department and also part of a specialty (or include providers with multiple specialties), so determining whether accessible MDE was dispersed with precision across each department, clinic, and specialty could become complex.

Even if a public entity's facility or program with multiple departments, clinics, or specialties will not be able to disperse its accessible MDE with mathematical precision across every department, clinic, and specialty, public entities must still afford people with disabilities an opportunity to benefit from each type of medical care that is equal to the opportunity provided to people without disabilities.[28] The Department recognizes that it is critically important for people with disabilities to have access to all types of medical care. Therefore, public entities are still required to ensure that all of their services, programs, and activities are accessible to and usable by individuals with disabilities, regardless of whether the dispersion provision in paragraph (b)(3) requires a specific department, clinic, or specialty to have accessible MDE.

The Department appreciates the comments it received on its proposed dispersion requirements. Though some commenters supported the Department's proposed approach to dispersion, many commenters did not believe the dispersion requirements were sufficient to meet the needs of individuals with disabilities. These commenters felt that additional requirements should be added to ensure adequate dispersion. Commenters proposed a range of different requirements, including requirements for each department or specialty; for every floor and building; for each facility; for every subpart of a larger entity that has the capacity to manage its own booking system; and for a particular geographic radius. Some commenters also proposed that each department, clinic, or specialty be required to have one or two examination tables and weight scales. One commenter supported a flexible approach to dispersion, whereby accessible MDE would be made available where it is needed.

For the reasons discussed in the section-by-section analysis of § 35.211(b), the Department continues to believe that the approach to dispersion set forth in § 35.211(b)(3) is appropriate and consistent with existing law. In light of the demands that increased dispersion requirements would impose on public entities, the Department is not expanding the dispersion requirements at this time. However, the Department emphasizes that compliance with the dispersion requirement does not excuse public entities from complying with their nondiscrimination obligations under the existing title II regulation or §§ 35.210 and 35.212.

The National Council on Disability, an independent Federal agency charged with advising the President, Congress, and other Federal agencies on policies, programs, practices, and procedures that affect people with disabilities, stated that the Department should require that as a facility or program acquires accessible MDE, it should ensure that at least one accessible examination table and one weight scale are located in every department, clinic, or specialty. The Department declines to adopt this suggestion so that public entities will retain the flexibility to determine how they will comply with the dispersion requirements in § 35.211(b)(3), in light of each public entity's particular circumstances. Though the text of § 35.211(b)(3) requires public entities to disperse, in a proportionate manner, the accessible MDE required by paragraphs (b)(1) and (2), the Department encourages public entities to disperse all of their accessible MDE proportionately, where they have more accessible MDE than paragraphs (b)(1) and (2) require.

Other commenters proposed that the Department require the dispersion of equipment or personnel other than MDE, such as wheelchairs that can be used around MRI scanners and patient lifts or transfer teams, as well as the dispersion of MDE based on weight or size capacity. The Department declines to adopt requirements for the other types of dispersion proposed by these commenters at this time. In this rulemaking, the Department is adopting the January 9, 2017, version of the MDE Standards promulgated by the Access Board [29] (with the exception of the sunset provisions, as explained in the section-by-section analysis of § 35.104) and making those standards enforceable. The MDE Standards do not include requirements for wheelchairs, equipment with greater weight or size capacity, patient lifts, or transfer teams. The Department will relay the commenters' views to the Access Board for consideration if the Access Board revises the MDE Standards on this subject in the future.

Many commenters raised concerns about the burdens that the approach to dispersion in subpart I of this part could impose on people with disabilities. These included delays in diagnosis and care, with the possibility of associated harm to the patient's health or life; increased wait times; cancelled or rescheduled appointments; a lack of expertise if patients need to receive some care from other departments or specialties; less effective treatment; the need for accessible, affordable transportation to other locations where accessible MDE is available; a lack of choice for patients with disabilities about where they will receive care; a lack of privacy if accessible MDE is located in a shared space; and embarrassment, humiliation, frustration, stress, and pain.

The Department reiterates that the lack of additional or more specific dispersion requirements than those set forth in § 35.211(b)(3) does not excuse public entities from complying with their nondiscrimination obligations under the existing title II regulation or §§ 35.210 and 35.212. If public entities' dispersion of accessible MDE imposes the burdens on individuals with disabilities that some commenters described, then that situation could result in discrimination because the public entity's MDE is not readily accessible to and usable by persons with disabilities as required by § 35.210. Likewise, such a situation could result in the public entity's service, program, or activity in its entirety not being readily accessible to and usable by patients with disabilities as required by § 35.212. Public entities are encouraged to acquire additional accessible MDE and disperse that MDE across departments, clinics, and specialties to better meet the needs of patients with disabilities.

One commenter proposed that the Department adopt a specific limit on wait times to ensure that people with disabilities do not have to wait significantly longer to access services than people without disabilities because of the amount of accessible MDE in a particular location or because patients need to travel to a different location to use accessible MDE. The Department declines to adopt a specific wait time limit because whether a particular wait time is justifiable may depend on the circumstances, including the overall demand for services and the wait times experienced by patients without disabilities. However, the Department notes that if patients with disabilities experience significantly longer wait times than patients without disabilities seeking comparable services at comparable times, this could violate § 35.210 or § 35.212.

Other commenters asked the Department to require public entities to offer and pay for accessible transportation when patients need to travel to other locations to use accessible MDE. The Department declines to adopt this requirement at this time because it has concluded that the requirements set forth elsewhere are sufficient to address the commenters' concerns. More specifically, a

[27] *See, e.g.,* 36 CFR part 1191, appendix B, sections 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.

[28] *See* §§ 35.130(b)(1)(ii) and 35.150(a).

[29] 36 CFR part 1195 (revised as of July 1, 2017).

failure to provide accessible transportation when patients with disabilities need to travel to other locations to use accessible MDE, but nondisabled patients do not need to travel to other locations to receive care, or a requirement that patients incur additional costs to use accessible MDE, could violate § 35.210 or § 35.212 or more generalized nondiscrimination requirements in the existing title II regulation.[30]

Many commenters also raised concerns about the burdens that the approach to dispersion in § 35.211(b)(3) may impose on public entities. Some commenters stated that it might be difficult or impossible for some types of MDE to be moved, but commenters also noted that some types of MDE might be more portable or easily shared. A few commenters stated that there might not be sufficient space in some existing medical facilities for accessible MDE. Other commenters noted potential difficulties that may arise if public entities share accessible MDE between clinics or departments. These include delays and increased wait times; the need to identify, locate, move, and track accessible MDE; the need to transport patients; the need to recalibrate MDE after it is moved; unnecessary work for staff to locate or move accessible MDE if the patient who needed it has to reschedule; conflicts among multiple patients or departments who need the accessible MDE; last-minute needs for accessible MDE; and the need to determine how to provide care if shared accessible MDE is not available. While the Department acknowledges and appreciates the concerns raised by these commenters, it declines to change the dispersion requirement of paragraph (b)(3) because, for all of the reasons already stated, it finds that the current requirement is appropriate. Further, some of the challenges noted by these commenters might be mitigated by exercising the flexibility public entities retain to determine how they will meet the dispersion and nondiscrimination requirements in subpart I of this part, so long as they satisfy the minimum scoping requirements in § 35.211(b)(1) and (2).

Commenters also stated that, to share or move accessible MDE, patients would need to provide notice of their need for accessible MDE when booking an appointment and opined that booking systems and public information should clearly indicate where and when accessible MDE is available. At this time, the Department declines to adopt additional procedural requirements that certain information about the availability of accessible MDE be made available or that the need for accessible MDE be recorded as part of the booking process because public entities should have flexibility to meet the requirements of subpart I of this part in a manner that is appropriate to their resources and systems. However, it may be helpful or necessary for public entities to request information about patients' needs and make information about accessible MDE available to patients and staff where feasible. Doing so is likely to better position public entities to provide care in a nondiscriminatory manner, while enabling patients with disabilities to make informed decisions about their care. Providing information to staff about the availability of accessible MDE may also enable public entities to meet their other obligations under subpart I of this part, including the obligation in § 35.213 to ensure that their staff are able to carry out the program accessibility obligation set forth in § 35.212.

The Department recognizes there may be situations in which a public entity's facility or program shares one piece of a particular type of accessible MDE among all departments, clinics, or specialties. In a small facility or program with a limited number of departments, clinics, or specialties in the same building, that situation may provide equal access for all patients with disabilities who need accessible MDE. However, depending on the circumstances, it may be necessary or advisable to have at least one unit of accessible MDE in each department, clinic, or specialty, so that patients with disabilities do not need to traverse between departments, clinics, or specialties for care. The Department recognizes the varying circumstances of different public entities and health care settings. Whether a public entity can share accessible MDE between departments, clinics, or specialties and still carry out its obligations under subpart I of this part will depend on the circumstances.

Public entities must ensure that the dispersion of their accessible MDE does not discriminate against people with disabilities. If a public entity requires a patient with a disability who needs accessible MDE to use the MDE of another department, clinic, or specialty, or to use MDE in a different location, the public entity must ensure that the MDE and the service, program, or activity in its entirety are readily accessible to and usable by the patient, as required by §§ 35.210 and 35.212. Factors to consider in determining whether this standard has been met may include, among other things, whether the MDE is readily available and not a significant distance from where the patient is seeking care; whether changing locations during the patient visit significantly increases wait times; whether the patient is required to be undressed or partially dressed to use the MDE (if, for example, the patient has to go to a different part of the same building to use the accessible MDE); and whether the public entity provides assistance in moving between locations.

A public entity may be able to take other measures to ensure that its MDE and its services, programs, and activities in their entirety are readily accessible to and usable by patients with disabilities. For example, it could offer home visits that provide equal access to care or accessible transportation to patients with disabilities at no cost to them within a reasonable timeframe.

Section 35.211(c) Requirements for Examination Tables and Weight Scales

Section 35.211(c) sets forth specific requirements for examination tables and weight scales. Paragraph (c)(1) requires 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 MDE Standards, unless the entity already has one. Similarly, 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 MDE Standards, unless the entity already has one. This requirement is subject to the other requirements and limitations set forth in § 35.211. Thus, § 35.211(c) 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, as explained in § 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.

The Department received many comments in support of the requirements set forth in § 35.211(c), including comments from public entities and individuals with disabilities. Many commenters provided firsthand accounts of being unable to receive health care or receiving substandard care because of a lack of accessible examination tables or weight scales. Commenters also described receiving incomplete physical examinations because they could not transfer to an examination table, or forgoing routine examinations, such as abdominal palpations and breast examinations, due to a lack of accessible examination tables. Some noted that many medicines, including chemotherapy and anesthesia, are dosed based on weight, yet a lack of accessible weight scales makes it impossible for many people with disabilities to be accurately weighed. Similarly, disability advocacy groups shared representative accounts of harms that people with disabilities have experienced due to the inaccessibility of examination tables and weight scales.

Some commenters expressed concern that the requirements set forth in § 35.211(c) are insufficient. A few commenters urged the Department to require public entities to obtain more than one examination table or weight scale, particularly in facilities that focus on conditions that affect mobility. Other commenters asked the Department to require one examination table and weight scale per department, clinic, or specialty. The Department clarifies that the requirements in § 35.211(c) must be viewed in conjunction with the other requirements of subpart I of this part. For example, although § 35.211(c) requires public entities to obtain at least one accessible examination table and at least one accessible weight scale within two years, public entities may be required to obtain more than one examination table or weight scale based on the scoping requirements set forth in § 35.211(b). In addition, public entities are subject to the nondiscrimination and program access obligations in §§ 35.210 and 35.212, and the acquisition of multiple accessible examination tables or weight

[30] *See, e.g.,* §§ 35.130(b)(1)(ii) and (f) and 35.150(a).

scales may be the most effective way to satisfy those obligations.

The Department requested public comment on the potential impact of the requirements in § 35.211(c) on people with disabilities and public entities. Several disability advocacy groups wrote that there are accessible weight scales on the market at varying costs, and that covered entities can also purchase or lease refurbished weight scales. The National Council on Disability commented that the economic impact on public entities will be modest and will be offset by the positive economic impact of more people being able to access preventative care. One commenter who uses a wheelchair noted that frequent delays during medical appointments due to a shortage of accessible examination tables and weight scales cost her money by preventing her from working.

Offering a different perspective, a few commenters expressed concern that it will be too expensive or logistically burdensome for providers to acquire the accessible MDE that § 35.211(c) requires. Some commenters suggested that the Department help providers pay for accessible MDE, including accessible examination tables and weight scales.

While the Department acknowledges the concerns of health care providers that will be required to carry out the obligations set forth in § 35.211(c), giving providers two years to meet the requirement for examination tables and weight scales, in particular, will improve access to basic diagnostic services for individuals with disabilities, while permitting providers to plan for the costs. Many of the comments that the Department received that describe the experiences of people with disabilities demonstrate the need for this requirement and the harm that a lack of accessible examination tables and weight scales can cause.

Regarding commenters' concerns about the cost of compliance, the Department does not currently operate a grant program to assist public entities in complying with the ADA. However, the Department notes that, pursuant to § 35.211(e), public entities are not required to take any action that would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens. Given the availability of these limitations, the Department believes it is appropriate to retain the requirements set forth in § 35.211(c).

Regarding whether two years is an appropriate amount of time for entities to comply with the requirements in § 35.211(c), commenters had diverse perspectives. While many commenters agreed with the Department's choice of two years, some, including individuals with disabilities, the National Council on Disability, and disability advocacy groups, stated that two years is too long. Others stated that two years is not long enough for public entities to comply with this requirement, particularly if entities have limited resources or if equipment is not readily available. Some commenters suggested a phased implementation approach.

Given the health disparities and barriers to care facing individuals with disabilities,[31] and the importance of examination tables and weight scales for the provision of basic health care services, the Department does not believe an extension of the two-year requirement or a phased implementation period for particular types of public entities is warranted. The fundamental alteration and undue burdens provisions account for the difficulty that some entities might have complying with the requirements of subpart I of this part.

The Department also does not believe a period shorter than two years for compliance with § 35.211(c) is warranted. Although the Department recognizes that individuals with disabilities face urgent health care needs, the Department must also consider the ability of entities to budget for and obtain accessible examination tables and weight scales under a feasible timeframe. Given all of these factors, the Department finds it appropriate to impose a two-year timeline for complying with the requirements for examination tables and weight scales in § 35.211(c).

The Department notes, however, that even before the two-year requirement goes into effect, public entities are required to make their services, programs, and activities, including those that use MDE, accessible to people with disabilities. Even before the two-year deadline, if an entity denies a physical examination or fails to take an accurate weight because of a lack of an accessible examination table or weight scale, that may implicate the nondiscrimination obligation set forth in § 35.210 and the program access obligation set forth in § 35.212, as well as the obligations set forth in the existing title II regulation.

Some commenters, including a State entity, the National Council on Disability, and multiple disability advocacy groups, expressed concern that, other than examination tables and weight scales, public entities are not required to obtain additional types of MDE within a specified period of time. The Department imposed a two-year requirement for examination tables and weight scales because those two types of equipment are very common among primary care providers, important for a range of basic diagnostic health services, and relatively attainable compared to more expensive accessible imaging equipment.[32] Many people with disabilities are unable to receive even the most basic health care services because of inaccessible examination tables and weight scales. In view of demands on provider entities, particularly small practices and rural facilities, the Department will not require public entities to obtain accessible MDE other than examination tables and weight scales within two years. Public entities will, however, be required to ensure that other types of MDE are accessible when they are acquired in accordance with § 35.211(a), and they will be required to comply with §§ 35.210 and 35.212. And as discussed elsewhere in this appendix, the most effective way to carry out the requirements set forth in §§ 35.210 and 35.212 may be to acquire multiple types of accessible MDE, not only examination tables and weight scales.

Section 35.211(d) Equivalent Facilitation

Paragraph (d) of § 35.211 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 provision applies only where the use of the alternative designs, products, or technologies results in substantially equivalent or greater accessibility and usability of the health care service, program, or activity 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 require. The responsibility for demonstrating equivalent facilitation rests with the public entity.

Several commenters wrote in support of the equivalent facilitation provision in § 35.211(d). A couple of commenters

[31] *See* C. Brooke Steele et al., *Prevalence of Cancer Screening Among Adults With Disabilities, United States, 2013,* 14 Preventing Chronic Disease (Jan. 2017), *https://www.cdc.gov/pcd/issues/2017/16_0312.htm* [*https://perma.cc/T36Y-NCJM*] (finding disparate access to cancer screenings); Gloria Krahn, *Persons with Disabilities as an Unrecognized Health Disparity Population,* 105 Amer. J. Pub. Health 198 (Apr. 2015), *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4355692/* [*https://perma.cc/J8E4-J63T*] (finding higher prevalence of obesity and cardiovascular diseases); *see also* Michael Karpman et al., *QuickTake: Even with Coverage, Many Adults Have Problems Getting Health Care, with Problems Most Prevalent Among Adults with Disabilities,* Urban Inst. Health Pol'y Ctr. (Sept. 2015), *https://apps.urban.org/features/hrms/quicktakes/Many-Adults-Have-Problems-Getting-Health-Care.html* [*https://perma.cc/V6GB-AEPH*]; Carrie Henning-Smith et al., *Delayed and Unmet Need for Medical Care Among Publicly Insured Adults with Disabilities,* 51 Med. Care 1015 (Nov. 2013), *https://pubmed.ncbi.nlm.nih.gov/24113815/* [*https://perma.cc/KSY2-DGEV*]; Amanda Reichard et al., *Prevalence and Reasons for Delaying and Foregoing Necessary Care by the Presence and Type of Disability Among Working-Age Adults,* 10 Disability & Health J. 39 (Jan. 2017), *https://pubmed.ncbi.nlm.nih.gov/27771217/* [*https://perma.cc/V7D7-LCQK*]; Michelle Stransky et al., *Provider Continuity and Reasons for Not Having a Provider Among Persons With and Without Disabilities,* 12 Disability & Health J. 131 (Jan. 2019), *https://pubmed.ncbi.nlm.nih.gov/30244847/* [*https://perma.cc/2LSR-PEGJ*]; Sarah Bauer et al., *Disability and Physical and Communication-Related Barriers to Health Care Related Services Among Florida Residents: A Brief Report,* 9 Disability & Health J. 552 (July 2016), *https://pubmed.ncbi.nlm.nih.gov/27101882/* [*https://perma.cc/YH6F-22UW*] (finding barriers to access to care).

[32] *See* Access Board, *Access Board Review of MDE Low Height and MSRP* (May 23, 2023), *https://www.regulations.gov/document/ATBCB-2023-0001-0002* [*https://perma.cc/WU3U-DP65*] (listing available examination table models that meet the height requirements of the MDE Standards and their retail prices). On the affordability of accessible examination tables and weight scales compared to imaging equipment, see 82 FR 2829 (stating that commenters were concerned about immediate compliance with the MDE Standards for ''more expensive imaging equipment'' compared to other accessible MDE). *See also* Block Imaging, *2024 Mammography Price Guide, https://www.blockimaging.com/bid/95356/digital-mammography-equipment-price-cost-info* [*https://perma.cc/2STC-34VW*].

suggested that the Department clarify that use of equivalent facilitation must not result in improved access to one group of people with disabilities at the expense of reduced access for others. The Department agrees that this provision does not apply if the use of an alternative design, product, or technology would make the health care service, program, or activity less accessible or usable for individuals with disabilities (or any group of individuals with disabilities) than the MDE Standards require.

The same commenters also recommended that the Department require entities to individually assess the preferences and needs of people with disabilities and receive informed consent before using an alternative option. The Department declines to require entities to individually assess the preferences and needs of people with disabilities and receive informed consent before using alternative designs, products, or technologies. This provision is modeled on existing language in the ADA Standards.[33] Adopting the approach that commenters proposed would create inconsistency between subpart I of this part and other portions of the Department's title II regulation,[34] which does not include the requirements for equivalent facilitation that commenters suggested. Further, requiring entities to engage in that sort of assessment with current or prospective patients could create an unworkable framework for public entities that had already obtained products that afforded equivalent or greater accessibility than the MDE Standards. However, nothing in this part requires patients to receive diagnostic health care services that they would prefer not to receive.

Section 35.211(e) Fundamental Alteration and Undue Burdens

Paragraph (e) of § 35.211 addresses the fundamental alteration and undue financial and administrative burdens limitations. While subpart I of this part generally requires public entities to adhere to the MDE Standards when newly purchasing, leasing, or otherwise acquiring MDE, 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 undue financial and administrative burdens. These limitations mirror the existing title II regulation at § 35.150(a)(3). If a particular action would result in a fundamental alteration or undue burdens, the public entity is obligated to 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 the public entity provides.

Many commenters wrote in support of the fundamental alteration and undue burdens limitations, with some noting that the approach strikes a thoughtful balance that will promote equal access to MDE for people with disabilities while mitigating the challenges and costs of implementation for public entities. While some commenters objected to the cost of complying with subpart I of this part, others said cost and acquisition difficulties should not be an excuse for noncompliance. A few commenters wrote that it is unlikely that an entity will reasonably be able to rely on these limitations at all. Some commenters wrote that people with disabilities historically have been forced to carry the burden, and the provision should consider the burden on people with disabilities in terms of factors like wait times, extra costs, and the availability of accessible providers. Some commenters asked the Department to clarify or define certain terms, such as ''undue burden'' or ''fundamental alteration.'' One comment suggested a particular method for making an undue burden calculation.

A few commenters recommended that the Department establish exceptions according to a different framework. One suggested that the Department exempt whole categories of entities, including small practices, new practices, and practices in areas with a health professional shortage. Others suggested that the Department extend the compliance timeframes for certain categories of entities, including small, rural, and ''safety-net'' entities.

The Department acknowledges commenters' concerns that the fundamental alteration and undue burdens limitations will undermine access for people with disabilities. However, these limitations fall within the well-established title II framework,[35] and it is important for these limitations on obligations to remain consistent with part 35 as a whole. These limitations also require a more individualized inquiry than the categorical exceptions that some commenters suggested and will therefore strike a better balance between the accessibility needs of individuals with disabilities and the potential difficulties of compliance in particular circumstances. As noted in the preceding paragraphs, if an action would result in a fundamental alteration or undue burdens, the public entity must still take any other action that would ensure that individuals with disabilities receive the benefits or services the public entity provides.

Because fundamental alteration and undue burdens are longstanding limitations under the ADA,[36] members of the public and public entities should already be familiar with these limitations in other contexts. The Department has provided guidance that addresses the fundamental alteration and undue burdens limitations, and will consider providing more in the future.[37] The Department's existing guidance documents provide details on fundamental alteration and undue burdens determinations, including language explaining that such determinations should consider all resources available for use in the funding and operation of the service, program, or activity.[38] In the Department's view, this guidance will help public entities use the fundamental alteration and undue burdens limitations appropriately.

Section 35.211(f) Diagnostically Required Structural or Operational Characteristics

Paragraph (f) of § 35.211 incorporates what M201.2 of the Access Board's MDE Standards refers to as a General Exception.[39] 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 is not required.

In the NPRM, the Department sought comment on whether the proposed exception in § 35.211(f) is needed. Multiple commenters supported the Department's approach, describing it as ''thoughtful'' and ''balance[d].'' Other commenters disagreed with this exception and recommended that the Department remove or amend it, stating that the exception is unnecessary, that it will be an overused loophole, or that it will stifle innovation.

While the Department appreciates commenters' opinions and concerns and recognizes the importance of providing accessible MDE to people with disabilities, the Department continues to believe that this exception is sometimes needed to preserve the functionality of MDE. For instance, as noted in the NPRM, the Department is aware that certain positron emission tomography (''PET'') machines cannot meet the MDE Standards' technical requirements for accessibility and still serve their diagnostic function. Commenters did not provide information that called this into question. Rather, the Department received numerous comments, including several comments regarding radiological diagnostic services, stating that this exception is essential. These commenters expressed concern that the MDE Standards are incompatible with the safe design and use of some types of diagnostic imaging equipment. With respect to MRI machines in particular, a disability rights organization observed that structural attributes may prevent certain equipment from being made accessible, and noted the importance of providing alternatives to ensure accessibility for individuals who use metal wheelchairs or assistive equipment.

In light of these factors, the Department will retain the exception in § 35.211(f). The Department expects, however, that this exception will apply only in rare cases. In such circumstances, the public entity must still take any other action that would not result in a fundamental alteration or undue burdens but would nevertheless ensure that individuals with disabilities receive the services, programs, or activities the public entity provides. For example, a PET machine that could not meet the MDE Standards and

[33] 28 CFR part 36, appendix D, at 1000 (2022) (1991 ADA Standards); 36 CFR part 1191, appendix B, at 329 (2022) (2010 ADA Standards).

[34] *See, e.g.,* § 35.151(c) (allowing or requiring public entities to comply with the 1991 ADA Standards or 2010 ADA Standards).

[35] *See* appendix B to this part.

[36] *See id.* §§ 35.130(b)(7), 35.150(a)(3), and 35.164.

[37] *See, e.g.,* U.S. Dep't of Just., *ADA Update: A Primer for State and Local Governments, ADA.gov* (Feb. 28, 2020), *https://www.ada.gov/resources/title-ii-primer/* [*https://perma.cc/ZV66-EFWU*].

[38] *Id.*

[39] 36 CFR part 1195, appendix, section M201.2 (revised as of July 1, 2017).

still serve its diagnostic function would not be required to meet the MDE Standards as a whole, but the public entity would still be required to meet all other applicable provisions of the MDE Standards, and to take any other action that would ensure that individuals with disabilities receive the public entity's benefits or services without fundamentally altering the nature of the service, program, or activity, or imposing undue financial and administrative burdens. Such actions could include, for example, assisting patients with transferring to the scan table so that they can receive a PET scan.

With respect to a commenter's concern that this exception will stifle innovation, the Department appreciates both the value of innovation and the importance of ensuring that MDE used by individuals with disabilities can be used safely and in accordance with its intended diagnostic purpose, given the constraints of existing technology. The Department believes § 35.211(f) strikes an appropriate balance between these interests. Further, the reason for allowing for equivalent facilitation in § 35.211(d) is to encourage flexibility and innovation by public entities while still ensuring equal or greater access to MDE.

In addition to commenters who recommended that the Department eliminate the exception in § 35.211(f), some commenters suggested changes to the regulatory text. One commenter suggested that the regulatory text should include language from the section-by-section analysis relating to the rare use of the provision and assistance transferring to a PET machine. The Department declines to incorporate these points into the regulatory text. Because the forgoing discussion reflects the Department's expectation about the rare applicability of this provision, and because the discussion about PET scans is one representative example, this discussion is more appropriately situated in this appendix than in the regulatory text.

A few commenters asked the Department to require that, where equipment's structural or operational characteristics implicate the fundamental alteration limitation, covered entities must consider all possibilities to ensure the dignity and independence of the person with a disability. The Department declines to amend the regulatory text to explicitly state that public entities must consider all possibilities to ensure the dignity and independence of people with disabilities. While the Department encourages public entities to do so to the extent feasible, the Department believes that the obligations set forth in the regulatory text in §§ 35.210 and 35.212, when read together with the ADA and the general prohibition on discrimination in its implementing regulation, are sufficient to prevent discrimination without further changes to this section.[40]

Section 35.212 Existing Medical Diagnostic Equipment

In addition to the requirements for newly purchased, leased, or otherwise acquired MDE, § 35.212 requires that public entities address access barriers resulting from a lack of accessible MDE in their existing inventory of equipment. Here subpart I of this part adopts an approach analogous to the concept of program accessibility in the existing regulation implementing title II of the ADA.[41] 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 regulation, by offering access to those programs through alternative methods. The Department adopts a similar approach with respect to 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.

Section 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 burdens. As addressed in more detail in the discussion of these limitations in the section-by-section analysis of § 35.211(e), the fundamental alteration and undue burdens 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 burdens, the public entity is still obligated to take any other action that would ensure that individuals with disabilities are able to receive the public entity's benefits and services. As with the fundamental alteration and undue burdens limitations, the discussion of the exception relating to diagnostically required structural or operational characteristics contained in the section-by-section analysis of § 35.211(f) applies equally to the Department's approach to this exception in § 35.212(a)(3).

The Department is also correcting a typographical error in § 35.212(a)(3). Section 35.212(a)(3) states that an entity meets its burden of proving that compliance with § 35.212(a) would result in a fundamental alteration under § 35.212(a)(2) if it demonstrates that compliance with § 35.212(a) would alter diagnostically required structural or operational characteristics of the equipment and prevent the use of the equipment for its intended diagnostic purpose. The NPRM mistakenly referred to § 35.211(a) and (c) rather than to § 35.212(a).

Section 35.212(b) describes 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 set forth in § 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 § 35.211, a public entity is not required to purchase, lease, or otherwise acquire accessible MDE if other methods are effective in achieving compliance with subpart I of this part.

For instance, 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) require a public entity's medical practice to have three accessible examination tables and an accessible weight scale, but the practice's existing equipment includes only one accessible examination table and one accessible scale, then until the practice must comply with § 35.211, the practice can ensure that its services are readily accessible to and usable by people with 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.[42]

If a public entity carries out its obligation under § 35.212(a) to make a service, program, or activity readily accessible to and usable by people with disabilities by purchasing, leasing, or otherwise acquiring accessible MDE, then that newly purchased, leased, or otherwise acquired MDE must comply with the requirements set forth in § 35.211.

Several commenters recommended that the Department include more specificity regarding the methods by which public entities must make their services, programs, and activities readily accessible to and usable by individuals with disabilities. For example, one commenter suggested that the Department establish a clear and defined test to assess compliance with the program access obligation. Another commenter suggested

[40] *See, e.g.,* 42 U.S.C. 12101(a); § 35.130(b).

[41] *See* § 35.150.

[42] *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/resources/medical-care-mobility/* [*https://perma.cc/UH8Y-NZWL*].

that the Department establish thresholds to determine whether public entities provide an equal opportunity to participate in or benefit from the service, program, or activity. Citing the Department's statement in the NPRM that allowing a patient to use accessible MDE at an alternative location would not give a patient with a disability an equal opportunity to participate in or benefit from the service, program, or activity if it was significantly less convenient or resulted in higher costs for the patient, the commenter suggested that the Department define how inconvenient an alternative location must be, either in terms of distance or in terms of travel time, in order to violate § 35.212(a).

The Department acknowledges these concerns and the commenters' desire for more clearly defined parameters, but notes that the concept of services, programs, and activities being readily accessible to and usable by individuals with disabilities is a longstanding requirement under title II of the ADA in other contexts.[43] Therefore, members of the public and State and local governments should already be familiar with this obligation. The Department has also provided guidance that addresses this concept,[44] and will consider providing more in the future. The Department operates a toll-free ADA Information Line that the public can call for assistance understanding the requirements of the ADA. The question of whether a particular service, program, or activity, in its entirety, is readily accessible to and usable by individuals with disabilities will be an inherently fact-bound inquiry.

Some commenters recommended that the Department require public entities to engage in an interactive process with patients and consider patients' preferences and needs in determining how to carry out their program access obligations. An ''interactive process'' is a term of art that applies in the ADA title I context but not the ADA title II context, and the Department declines to require such a process in subpart I of this part.[45] However, it may often be helpful or necessary for public entities to consider patients' preferences and needs in order to ensure that the entity's services, programs, and activities, in their entirety, are readily accessible to and usable by individuals with disabilities. For example, using the scenario discussed in the preceding paragraphs, a medical practice that lacks accessible MDE at its primary location might be able to achieve program accessibility by serving a patient who needed accessible MDE at an alternative location. But the practice would first need to determine how difficult it would be for the patient to travel to the alternative location. As explained in the preceding paragraphs, if the alternative location was significantly less convenient or resulted in higher costs for the patient, it would not provide an equal opportunity to participate in or benefit from the service, program, or activity.

One commenter asked whether public entities can continue to use existing MDE that meets some but not all of the requirements set forth in the MDE Standards. The commenter asked whether, for example, an entity can use an adjustable height examination table that lowers to the minimum height but does not raise to the upper height set forth in the MDE Standards. As § 35.212(b) explains, § 35.212(a) does not require public entities to acquire MDE that meets all of the requirements set forth in the MDE Standards if other methods enable them to make their services, programs, and activities, in their entirety, readily accessible to and usable by individuals with disabilities. Using MDE that meets some but not all of the requirements set forth in the MDE Standards may, in some cases, be one way for public entities to carry out their program access obligation under § 35.212(a). In contrast, newly acquired MDE must meet all of the requirements set forth in the MDE Standards pursuant to § 35.211(a), absent an applicable limitation.

Finally, one commenter recommended that the Department add a requirement from the ADA title III regulations that ''a public accommodation shall remove architectural barriers in existing facilities where such removal is readily achievable, *i.e.,* easily accomplishable and able to be carried out without much difficulty or expense.'' [46] The readily achievable barrier removal standard applies to architectural barriers, not barriers in equipment, and importing requirements from the ADA title III regulation into subpart I of this part could create confusion and inconsistency with the other obligations in subpart I and with the rest of the title II regulation. Additionally, MDE often cannot be retrofitted to be accessible with the same ease or cost ratio as many forms of readily achievable barrier removal, such as adding raised markings to elevator buttons or providing paper cups at an inaccessible water fountain. The Department therefore declines to import the readily achievable barrier removal standard into the final rule.

Section 35.213 Qualified Staff

Section 35.213 requires public entities to ensure that their staff members 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 members are able to successfully operate accessible MDE is to provide staff training on the use of MDE, but the final rule does not mandate that approach.

The Department received comments on this issue from a range of stakeholders, including individuals with disabilities, disability advocacy organizations, and health care providers. Many commenters supported the Department's proposal. In response to the Department's request for comments on the effectiveness of programs used to ensure that staff are qualified, several disability advocacy organizations noted that even when a health care provider has accessible MDE, staff are sometimes unable to operate it. Many people with disabilities and disability advocacy organizations also described interactions with staff who were not able to provide assistance with transfers or did not provide program access in other ways. These accounts supported the need for § 35.213, which explicitly requires public entities to ensure that their staff members are able to successfully operate accessible MDE, assist with transfers, and ensure program access.

A disability advocacy organization proposed that the Department revise the text of § 35.213 to include personnel who are responsible for scheduling appointments and maintaining accessible MDE, and to require public entities to ensure that staff members are able to maintain accessible MDE and ensure scheduling times and reservations appropriate for patients with disabilities. The Department believes that the current language of the general nondiscrimination obligation set forth in § 35.210 and the program access obligation set forth in § 35.212, in conjunction with the other provisions in the title II regulation that require equal access and maintenance of accessible features,[47] is sufficient to address the issues raised by the commenter. The Department also notes that § 35.213 pertains to public entities' staff but is not limited to particular types of staff. As with the other topics for training discussed in the section-by-section analysis of § 35.213, public entities may find that providing their staff with the training this commenter described is often the most effective way to meet their obligations under subpart I of this part and other parts of the ADA. The lack of a specific requirement to provide training to these personnel regarding these issues would not excuse a related ADA violation.

Only one commenter opposed § 35.213. This commenter stated that requiring public entities to ensure that their staff members are able to assist with transfers would lead to discrimination against employees with disabilities who are not physically able to assist with transfers. The Department notes that subpart I of this part does not supersede or alter title I of the ADA or occupational safety standards, or redefine the essential functions of any particular employee's job.[48] Qualified employees with disabilities remain entitled to reasonable accommodations as specified in existing law.[49] However, an individual employee's need for accommodations does not diminish the rights of other individuals with disabilities to have

[43] *See, e.g.,* §§ 35.150 and 35.151.

[44] *See, e.g.,* U.S. Dep't of Just., Civ. Rts. Div., *ADA Update: A Primer for State and Local Governments* (Feb. 28, 2020), *https://www.ada.gov/resources/title-ii-primer/* [*https://perma.cc/ZV66-EFWU*]; U.S. Dep't of Just., *Title II Assistance Manual: Covering State and Local Government Programs and Services, https://archive.ada.gov/taman2.html* [*https://perma.cc/6QNC-3RRA*].

[45] *See* 29 CFR 1630.2(o)(3).

[46] 28 CFR 36.304(a).

[47] *See, e.g., id.* §§ 35.130 and 35.133.

[48] *See* 42 U.S.C. 12111–12117.

[49] 42 U.S.C. 12112(b)(5); 29 CFR 1630.9.

equal access to the services, programs, and activities provided by a public entity.

Many commenters encouraged the Department to establish more explicit and specific requirements for training. Commenters provided a variety of suggestions for what these requirements should be, including certification; training by the manufacturers of accessible MDE; periodic ''refresher'' training; and training on additional topics, such as the maintenance of accessible MDE, appointment scheduling and booking accessible MDE, attitudinal barriers, implicit bias, ableism, disability culture, disability history, providing care to individuals with disabilities, transfer support and practice, the use of lifts, plain language, effective communication, and reasonable modifications. One commenter suggested that the Department should withhold Federal funding if certain training is not conducted. Many commenters stated that people with disabilities should be involved in training so that public entities are able to draw from individuals' lived experiences.

In response to the Department's request for comments on the costs of programs for ensuring qualified staff, a few commenters stated that the cost of training would be minimal, especially in comparison to the cost of an injury to individuals with disabilities or personnel. These commenters stated that proper training reduces the number of injuries to individuals with disabilities and staff, ultimately reducing costs for covered entities.

After considering all of these comments, the Department declines to impose more specific requirements in § 35.213. Training, including training on the topics commenters suggested, will often be the most effective way to for public entities to ensure compliance with the entity's obligations under subpart I of this part. Training developed in consultation with, or provided by, individuals with disabilities may be particularly effective. And the Department appreciates commenters' views that training may ultimately reduce costs. However, the Department believes it is important to provide public entities with flexibility to determine how they will comply with the qualified staff requirement. Appropriate methods for meeting this requirement may differ for small health care providers as opposed to large hospital systems, for example. The Department has therefore decided not to mandate one specific process or curriculum that all public entities must follow to comply with § 35.213.

Several commenters suggested steps the Department could take to assist covered entities in complying with this requirement and the other requirements set forth in subpart I of this part. Suggestions included providing additional guidance, technical assistance, training, and financial resources. Some commenters also suggested that the Department collaborate with manufacturers to provide instructions on how to use accessible MDE or encourage covered entities to request instructions during procurement. The Department notes that it has already provided some technical assistance.[50] If public entities would find it helpful to seek additional information from MDE manufacturers or vendors, the Department encourages entities to do so. As noted in the discussion of § 35.211(c), the Department does not currently operate a grant program to assist public entities in complying with the ADA. The Department will, however, continue to consider what additional guidance, technical assistance, or training it can provide that will assist regulated entities in complying with their obligations under subpart I of this part.

Public Comments on Other Issues in Response to NPRM

The Department received comments on a variety of other issues in response to the NPRM. Several commenters recommended that the Department prescribe specific steps that all entities must take in order to carry out the primary requirements in subpart I of this part, such as employing scheduling and reservation systems; maintaining and publishing lists of accessible inventory, including the location of such equipment; reimbursing patients for transportation costs to accessible facilities; using certain staff-to-patient ratios; having staff take notes on each patient's needs and the patient's level of understanding; providing communication access in American Sign Language and Braille; using patient lifts or transfer teams; and offering scales and health monitoring tools for home use to patients with transportation difficulties. Another commenter suggested that entities subcontract with disability groups to test MDE that the entities have purchased. Some commenters also suggested that the Department issue guidance on various topics.

While the Department appreciates commenters' thoughtful suggestions, the Department declines to prescribe that public entities must take these specific steps in order to carry out the requirements in subpart I of this part. The Department intends to instead give public entities and members of the public clarity about the requirements in subpart I of this part, while also giving public entities flexibility in determining how best to carry out those requirements based on their individual circumstances. Public entities may find that many of the approaches recommended in the comments summarized in the preceding paragraph will enable them to carry out the requirements in subpart I of this part. The Department will also consider providing additional guidance to public entities about how to comply with subpart I of this part.

Commenters also expressed concern that people with disabilities are not involved in decisions associated with their care, in general. One commenter suggested that all policies about people with disabilities should be formed in consultation with an advisory council of people with a range of disabilities. The Department agrees that it is important to involve people with disabilities in decisions involving the creation and implementation of disability-related rules and policies. Indeed, the technical standards that the Department is adopting were created by the Access Board, a coordinating body that includes 13 members of the public, most of whom are required to have a disability in order to be appointed to the Access Board.[51] The Department has also carefully considered comments on the NPRM from many members of the public who self-identified as having a disability. In addition, individuals with disabilities can file a complaint with the Department or file a private lawsuit if a public entity fails to carry out its title II obligations. Given the existing mechanisms to solicit feedback and receive complaints about implementation from individuals with disabilities, the Department declines to create an advisory council in connection with this part.

The Department also received a comment suggesting that it regularly review and update accessibility standards to reflect technological advancements and the evolving needs of individuals with disabilities. Executive Order 13563 already requires the Department to review its regulations periodically to determine whether they should be modified, streamlined, expanded, or repealed.[52] Further, section 510 of the Rehabilitation Act requires the Access Board, in consultation with the Food and Drug Administration, to periodically review and, as appropriate, amend the MDE standards.[53] Therefore, a separate mechanism for reviewing the effectiveness of this part is not necessary.

Finally, the Department received a few comments asking that it make the MDE Standards enforceable against title III entities. As noted in section II.A of the preamble to the final rule (''Statutory and Rulemaking Overview''), the Department will continue to consider issues concerning MDE under title III. The Department will also continue to consider further rulemaking on this topic. However, title III entities are not the subjects of this rulemaking.

Dated: July 26, 2024.

Merrick B. Garland,

Attorney General.

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[50] *See, e.g.,* 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/resources/medical-care-mobility/* [*https://perma.cc/UH8Y-NZWL*].

[51] U.S. Access Board, *About the U.S. Access Board, https://www.access-board.gov/about/* [*https://perma.cc/L9N7-56YV*].

[52] E.O. 13563, sec. 6, 3 CFR, 2011 Comp., p. 215.

[53] 29 U.S.C. 794f(c).

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket Number USCG–2024–0711]

RIN 1625–AA00

Safety Zone; M/V JACOB PIKE Dead Ship Tow, Harpswell, ME to South Portland, ME

AGENCY: Coast Guard, DHS.