particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 (adjusted for inflation) or more in any one year. Though this rule will not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

F. Environment

We have analyzed this rule under Department of Homeland Security Directive 023–01, Rev. 1, associated implementing instructions, and Environmental Planning COMDTINST 5090.1 (series), which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4370f), and have determined that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This rule involves a safety zone that will be enforced for five hours to prohibit entry within a 1000-foot radius of wire pulling operations. It is categorically excluded from further review under paragraph L60(a) of Appendix A, Table 1 of DHS Instruction Manual 023–01–001–01, Rev. 1. A Record of Environmental Consideration supporting this determination is available in the docket. For instructions on locating the docket, see the **ADDRESSES** section of this preamble.

G. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to call or email the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places, or vessels.

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 46 U.S.C. 70034, 70051, 70124; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 00170.1, Revision No. 01.3.

■ 2. Add § 165.T08–0659 to read as follows:

§ 165.T08–0659 Safety Zone; Gulf Intracoastal Waterway, Gibbstown, LA.

(a) *Location.* The following area is a safety zone: All navigable waters within a 1000-foot radius of the Gibbstown Bridge located at 29°56′01.2″ N and 093°04′47.3″ W, on the Gulf Intracoastal Waterway. These coordinates are based on WGS 84.

(b) *Definitions.* As used in this section, *designated representative* means a Coast Guard Patrol Commander, including a Coast Guard coxswain, petty officer, or other officer operating a Coast Guard vessel and a Federal, State, and local officer designated by or assisting the Captain of the Port Marine Safety Unit Port Arthur (COTP) in the enforcement of the safety zone.

(c) *Regulations.* (1) Under the general safety zone regulations in subpart C of this part, entry of vessels or persons into the zone described in paragraph (a) is prohibited unless authorized by the COTP or a designated representative. During the enforcement period, all persons and vessels permitted to enter the safety zone described in paragraph (a) must comply with the lawful order or directions of the COTP or a designated representative.

(2) To seek permission to enter the safety zone, contact the COTP or the COTP's representative on VHF–FM channel 13 or 16, or by phone at telephone at 337–912–0073.

(d) *Enforcement period.* This safety zone is in effect from July 23, 2024 through July 30, 2024. It will be subject to enforcement from 8:00 a.m. through 1:00 p.m. on the day of the wire pulling operations. The COTP or a designated representative will inform the public of the date of wire pulling operations through Broadcast Notices to Mariners and Marine Safety Information Bulletins as appropriate.

(e) *Informational broadcasts.* The COTP or a designated representative will inform the public of the effective period for the safety zone, as well as any changes in the date and times of enforcement, through Broadcast Notices to Mariners and Marine Safety Information Bulletins as appropriate.

Morgan Kelly,

Commander, U.S. Coast Guard, Acting Captain of the Port Marine Safety Unit Port Arthur.

[FR Doc. 2024–16360 Filed 7–24–24; 8:45 am]

BILLING CODE 9110–04–P

ARCHITECTURAL AND TRANSPORTATION BARRIERS COMPLIANCE BOARD

36 CFR Part 1195

[Docket No. ATBCB–2023–0001]

RIN 3014–AA45

Standards for Accessible Medical Diagnostic Equipment

AGENCY: Architectural and Transportation Barriers Compliance Board.

ACTION: Final rule.

SUMMARY: The Architectural and Transportation Barriers Compliance Board (hereafter, ''Access Board'' or ''Board''), is issuing this final rule to remove the sunset provisions in the Board's existing accessibility standards for medical diagnostic equipment related to the low height specifications for transfer surfaces, and replace them with a final specification for the low transfer height of medical diagnostic equipment used in the supine, prone, side-lying, and the seated position.

DATES: The final rule is effective September 23, 2024.

FOR FURTHER INFORMATION CONTACT: Accessibility Specialist Bobby Stinnette, (202) 272–0021, *stinnette@access-board.gov;* or Attorney Advisor Wendy Marshall, (202) 272–0043, *marshall@access-board.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The Access Board issues this final rule to amend 36 CFR part 1195 to establish a 17-inch low transfer height specification for transfer surfaces of medical diagnostic equipment used in the supine, prone, side-lying, and seated position. This final rule also removes the sunset provisions at 36 CFR 1195.1, appendix, M301.2.2 and M302.2.2, that were promulgated in 2017 to allow the Board additional time to determine the appropriate low height specification.

II. Legal Authority

Section 510 of the Rehabilitation Act charges the Access Board with developing and maintaining minimum technical criteria to ensure that ''medical diagnostic equipment used in or in conjunction with physician's offices, dental offices, clinics, emergency rooms, hospitals, and other medical settings, is accessible to, and usable by, individuals with accessibility needs, and shall allow independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible.'' 29 U.S.C.

794f. The Access Board's minimum technical criteria do not impose any mandatory requirements on health care providers or medical device manufacturers. Agencies or entities may issue regulations or adopt policies requiring health care providers to acquire accessible medical diagnostic equipment that complies with the technical criteria set forth by the Access Board. Agencies would be permitted to ''propose or adopt [such enforceable regulations] only upon a reasoned determination that the benefits of the intended regulation justify its costs,'' E.O. 12866 section 1(b)(6), a determination the Access Board has not made. These agencies or entities would have to develop the appropriate scoping provisions to determine how to apply these technical criteria and could strengthen or lessen the requirements.

III. Rulemaking History

In January 2017, the Board issued a final rule establishing technical criteria for medical diagnostic equipment. 82 FR 2810 (codified at 36 CFR part 1195). The Accessibility Standards for Medical Diagnostic Equipment (MDE Standards) set forth technical criteria to ensure that medical diagnostic equipment used by health care providers (such as examination tables, weight scales, and imaging equipment) is accessible to, and usable by, individuals with disabilities. One of the areas covered by the MDE Standards is the adjustability of transfer surfaces for diagnostic equipment used by patients in a supine, prone, side-lying, or seated position. The MDE Standards currently specify the following adjustability requirements for transfer-height surfaces: a high height of 25 inches, a low height of 17–19 inches, and four unspecified intermediate heights between the high and low transfer height, which are separated by a minimum of one inch. 36 CFR part 1195, appendix, M301.2.1 and M302.2.2. Unlike the other transfer height specifications, the low transfer height was set as a temporary range with a five-year sunset provision. *Id.*

As explained in the preamble to the final rule, the Board took this approach because ''there was insufficient information to designate a single minimum low height requirement at [that] time. Specifically, there [was] insufficient data on the extent to which and how many individuals would benefit from a transfer height lower than 19 inches.'' 82 FR 2816. The Board explained that the MDE Advisory Committee was unable to come to an agreement on a single low height transfer position.

In the 2013 MDE Advisory Committee Report, minority reports submitted by disability advocates and academics supported a minimum low height of 17 inches. *See* Minority Reports from Boston Center for Living Inc., National Network for ADA Centers, and Medical Diagnostic Equipment Advisory Committee, available at *https://www.regulations.gov/docket/ATBCB-2013-0009/document* (last visited Dec. 4, 2023). These reports referenced the importance of accessible care, ensuring as many independent transfers as possible, and minimizing the risk of injury to both patient and provider if an assisted transfer is necessary. The reports asserted that the 17-inch low height provides ''the greatest number of individuals the opportunity to transfer independently.'' 82 FR 2810, 2815 (Jan. 9, 2017).

The minority reports submitted in 2013 by manufacturers supported a minimum low height of 19 inches. *See* Minority Reports from Hologic, Inc., Midmark Corporation, Medical Imaging and Technology Alliance (MITA) Advisory Committee Members, and Recommendation of 19-inch Lower Adjustable Height as the Minimum Accessibility Standard (Joint Report), available at *https://www.regulations.gov/docket/ATBCB-2013-0009/document* (last visited Dec. 4, 2023). The exam table manufacturers asserted that they would incur costs to comply with the 17-inch low height, but not similarly for the 19-inch low height. The manufacturers asserted that, at that time, there were no accessible diagnostic tables on the market that met a 17-inch low height requirement. *Id.*

Thus, the Board decided to specify a five-year sunset period to afford time for needed research and subsequent promulgation of a final specification for the low transfer height position. *Id.* On February 3, 2022, the Board issued a direct final rule extending the sunset provision until January 10, 2025. 87 FR 6037 (Feb. 3, 2022).

The Board commissioned Dr. D'Souza to complete a secondary analysis of occupied seat heights based on the 2010 *Anthropometry of Wheeled Mobility Project* to address some of the concerns raised about the original study. In 2021 Dr. D'Souza completed the 2021 *Analysis of Low Wheelchair Seat Heights and Transfer Surfaces for Medical Diagnostic Equipment Final Report.* The report was presented at the Access Board's public meeting on May 12, 2022, and the Board solicited public comments on the report.

On May 23, 2023, following the completion of this research and review of the public comments received, the Access Board issued a notice of proposed rulemaking of Standards for Accessible Medical Diagnostic Equipment proposing to remove the sunset provision and replace the low-transfer-height specification range with a 17-inch requirement for medical diagnostic equipment used in the supine, prone, side-lying, and seated position. 88 FR 33056 (2023 MDE NPRM).

IV. Comment Review

In response to the 2023 MDE NPRM the Board received 76 comments: 60 from individuals, 7 from disability rights organizations, 2 from independent living centers, 6 comments from 4 manufactures and manufacturer/trade associations, and one comment from a health delivery system. In response to a request from MITA for an extension of the comment period to allow them to provide a more thorough comment, the Board extended the comment period by 30 days to August 31, 2023. Notice of proposed rulemaking extension of comment period, 88 FR 50096 (Aug. 1, 2023). Below the Board addresses each group of comments received.

The Board first acknowledges a few comments received from various individuals and entities suggesting there was some confusion about the sunset provision. The Board emphasizes that this final rule removes the sunset provision, the effect of which is to make the low transfer height of 17 inches and a high transfer height of 25 inches the applicable standard as of the effective date for this final rule. However, the MDE Standards are not enforceable unless adopted by an enforcement agency, and that agency would determine any effective date during its rulemaking process, which could include a delayed effective date for the low transfer height if appropriate.

There were also a few comments concerning whether equipment currently on the market that meets the MDE Standards as issued in 2017 would be exempt from the 17-inch low transfer height or would be deemed as ''not complying.'' That determination will be made by enforcement agencies if they adopt these or other requirements for MDE as enforceable standards.

Additionally, a few commenters raised concerns about a potential overlap or conflict between the MDE Standards and FDA's oversight and review of medical devices. In accordance with Section 510 of the Rehabilitation Act, the Access Board consulted with the Food and Drug Administration in the promulgation of this rule. 29 U.S.C. 794f(a). FDA advised

that the low transfer height standard generally does not appear to present safety or effectiveness issues, and FDA does not anticipate design changes implemented solely to conform to such a standard would preclude market authorization. FDA further advised that conformance or nonconformance with the MDE Standards low transfer height provision would not factor into FDA's evaluation of whether a device has satisfied the applicable legal standard to support marketing authorization. Based on that consultation, the Board has determined that there is no conflict between the MDE Standards and FDA's oversight and review of medical device.

A. Comments From Individuals

The Board received 60 comments from individuals, most of whom identified as having disabilities. The vast majority support the proposal and explain the commenters' experiences with inaccessible medical diagnostic equipment. Some of the commenters expressed a preference for a transfer height higher than 17 inches (which can be accomplished under the final rule requiring that the MDE be adjustable in height between 17 and 25 inches), and a few thought the transfer height should be as low as possible without specifying a height. None of the individual commenters, however, opposed the low transfer height of 17 inches.

B. Manufacturers and Trade Associations

The Access Board received comments from two manufacturers of medical diagnostic equipment, one trade association representing manufacturers of medical imaging equipment, and one association representing radiologists. The two manufacturers previously commented on the 2021 *Analysis of Low Wheelchair Seat Heights and Transfer surfaces for Medical Diagnostic Equipment Final Report.* These manufacturers also participated in the MDE Advisory Committee for the original rulemaking and provided comments during the public comment period for the original 2016 rulemaking. Many of the Comments submitted in response to the 2023 MDE NPRM reiterated previous comments received during the rulemaking process, including comments about the D'Souza research study, concerns about costs, and the ability of the table/chair to raise to a level comfortable for the medical professionals. Below we address the manufacturers' and trade association's comments, but also adopt the explanations provided in the preamble to the 2023 MDE NPRM. *See* 88 FR 33056, 33058–33060 (May 23, 2023).

(1) General Exception

One manufacturer of exam tables and chairs asserted that having to reduce the low transfer height to 17 inches would force manufacturers to alter structural or operational characteristics of MDE and would prevent the intended diagnostic purpose of the equipment. Additionally, the two associations voiced concern that height-adjustability may not be feasible for medical imaging devices due to technical limitations, and one asked for an exemption for advanced diagnostic imaging equipment from the adjustability requirement.

The MDE Standards address these concerns at M201.2 with a general exception that states that MDE ''shall not be required to comply with one or more applicable requirements in the MDE Standards in the rare circumstances where compliance would alter diagnostically required structural or operational characteristics of the equipment and would prevent the use of the equipment for its intended diagnostic purpose. Diagnostic equipment subject to M201.2 shall comply to the maximum extent practicable.'' 36 CFR 1195.1, appendix, M201.2.

In the preamble to the 2017 MDE final rule, the Board explained that this exception applies when the ''diagnostically required structural or operational characteristics cannot be made to comply with the technical requirements without preventing the use of the equipment for its intended purpose.'' *See* Standards for Accessible Medical Diagnostic Equipment, 82 FR 2810, 2813 (Jan. 9, 2017). In that case, this exception would require the equipment to lower as close to 17 inches as possible without affecting the diagnostic characteristics. In the 2017 MDE final rule, the Board specifically explained its expectation that some medical imaging equipment may have to rely on this general exception to ensure that the diagnostic characteristics are not compromised. The Board believes this exception may also be used in some cases for medical diagnostic equipment that does not currently reach 17 inches; however, the Board has not determined how often this would be the case as it will depend on the state of the market conditions and scoping requirements if this rule is adopted as an enforceable standard.

With respect to exam tables and chairs, one commenter asserted that a 17-inch low transfer height would make it impossible to move patients into the Trendelenburg position (head lower than feet), where required for medical and dental care. Although the general exception may be appropriate if such a position would not be attainable with a 17-inch low height requirement, the vast majority of dental chairs on the market already have a low transfer height at or below 17 inches. *See* notice of proposed rulemaking, Standards for Accessible Medical Diagnostic Equipment, 88 FR 33056, 33060 (May 23, 2023).

(2) Scoping

One comment from a manufacturer explained that while the number of height adjustable tables in the market is increasing in the United States, noting an increase from 5 percent in 2001 to 45 percent in 2023, the majority of tables on the market are still the fixed height table (32 inches) due to the cost. This commenter asserted that the adoption rate of adjustable tables would be further impeded with a requirement that the accessible MDE have a low transfer height of 17 inches. In response to the commenter's concern, the Board notes that if enforcement agencies adopt the MDE Standards, those agencies may provide scoping requirements prescribing the minimum percentage of MDE that would need to meet the MDE Standards. If an enforcement agency were to adopt the MDE Standards, only the percentage of MDE that the agency's regulation specified would have to meet them.

(3) Maintain the Current Range 17–19 Inches as the Final Specification

Two of the commenters recommend maintaining the 17–19-inch range as the final specification, asserting that it is consistent with existing accessibility standards for fixed elements where transfer is expected, such as water closets and toilet seats. These commenters stated that the widely accepted existing transfer height range of 17–19 inches suggest the importance of maintaining this standard for exam tables and procedure chairs. The Access Board refers these commenters to the preamble to the 2023 MDE NPRM where the Board addressed this concern and explained the difference between the height range provided for a fixed element in the ADA Accessibility Guidelines versus the low height provision for an adjustable transfer surface on MDE. There, we explained that the two situations are not the same, ''as [water closets and toilet seats] only provide one height for transfer, so in determining that height, the Board had to specify a range for a static height that would effectuate transfer for the majority of users. With MDE and the ability to have 6 different transfer points, the goal is to accommodate all people with disabilities who are able to

effectuate an independent transfer.'' *Id.* at 33061.

(4) Legacy Clause

One commenter recommended that a ''legacy clause'' be added to the MDE Standards that would allow MDE that complied with the MDE Standards prior to the finalization of the 17-inch low height to be considered accessible until replaced. As previously noted, if enforcement agencies adopt these technical standards, they will determine how previously compliant equipment should be treated.

(5) Use of 2010 Anthropometry of Wheeled Mobility Project Data

One of the commenters reasserted concerns with the methodology of the 2010 Anthropometry of Wheeled Mobility Project Data previously raised in response to D'Souza's 2021 *Analysis of Low Wheelchair Seat Heights and Transfer Surfaces for Medical Diagnostic Equipment Final Report. Available at https://www.access-board.gov/research/human/wheelchair-seat-height/.* The commenter again requested that the Board conduct additional studies on how level transfer can be achieved by individuals with disabilities and requests a definition of level transfer. The Board previously addressed these concerns in the preamble to the 2023 MDE NPRM and reiterates that based on the risk of falls and injuries to patients and providers, the success of transfer at a height level to a user's wheelchair, and the exertion needed for vertical transfer, providing a level transfer height for medical diagnostic equipment whenever possible ensures that almost everyone, if not everyone, who is capable of an independent transfer would be able to transfer to this adjustable height surface from 17 to 25 inches. *Id.* at 33059–33060.

(6) Cost and Time To Implement

One manufacturer responded to the questions posed in the 2023 MDE NPRM about the cost to manufacturers to modify current 18–19-inch MDE to comply with 17-inch low height requirements. This manufacturer asserted that its exam tables and chairs cannot be modified and would need to be completely redesigned in order to comply; that the development costs for redesign would be around $6 million and would take at least 17 years, assertedly what it took to reach 19 inches; and that the cost increase to the product itself would be 20–30%, which would not diminish over time. Later, the same commenter asserted it would take 10 years to redesign the equipment. Based on the change in availability of height adjustable exam tables and chairs since the publication of the MDE Standards in 2017, the Board is not convinced that compliant equipment would take 17 years to be redesigned, especially if this Standard is adopted and market demand for compliant equipment increases. However, the Board recommends that any agency adopting the MDE Standards consider the state of the market at the time of its adoption to determine if a delayed effective date for low transfer height is warranted.

C. Disability Rights Organizations/ Independent Living Centers

The Board received 9 comments from disability rights organizations and independent living centers. These comments fully supported the Board's proposed 17-inch low height. The Paralyzed Veterans of America (PVA) noted that accessible MDE is essential for full and equal access to healthcare services for wheelchair users. *Available at https://www.regulations.gov/comment/ATBCB-2023-0001-0058.* PVA explained that numerous studies show that people with disabilities cannot access routine medical exams and procedures because of inaccessible basic MDE, like exam tables and chairs, noting a longstanding devaluation of the lives of people with disabilities. Id.

Another commenter explained its enthusiastic support for the 17-inch provision, noting its awareness and understanding of the persistent and systemic barriers disabled people encounter when seeking medical care and that a 17 to 19-inch range would simply be akin to establishing a 19-inch low height. *Available at https://www.regulations.gov/comment/ATBCB-2023-0001-0060.*

Another commenter asserted that the older adult population is projected to dramatically increase in the coming years, climbing from 61.6 million today to 94.7 million by 2060 which will result in the increase of use of mobility devices as nearly 10 percent of older adults adopt mobility devices each year. *Available at https://www.regulations.gov/comment/ATBCB-2023-0001-0059.* Finally, one commenter strongly supports the largest range possible to provide access to the greatest number of people and recommended a low transfer height of 15 inches. Available at *https://www.regulations.gov/comment/ATBCB-2023-0001-0071.*

D. Health Care System

The Access Board received one comment from a health care system, Sutter Health, a not-for-profit health delivery system that operates 24 acute care hospitals and 200 clinics in Northern California. Sutter Health supports the change to a 17-inch low transfer height and noted that this change will ''improve access for people with disabilities.'' Sutter Health also explained that some manufacturers already produce medical equipment that meets this slightly stricter standard, and that its ''healthcare system has already made the 17'' low height transfer surface [its] standard for purchasing accessible medical equipment, and [it is] very pleased with the results.'' Sutter Health further stated, ''Cost has not been an issue.'' Comment of Sutter Health, available at *https://www.regulations.gov/comment/ATBCB-2023-0001-0065* (last visited Dec. 4, 2023).

V. Current Status of Accessible Medical Diagnostic Equipment

The Access Board informally reviewed publicly available information on current medical diagnostic equipment, specifically examination tables and chairs, to discern the current low transfer height and cost of adjustable MDE for the 2023 MDE NPRM. There, the Board provided an analysis of the current status of accessible medical diagnostic equipment and provided the *Access Board Review of MDE Low Height and MSRP* (December 2022). 88 FR 33056 (May 23, 2023) and *https://www.regulations.gov/docket/ATBCB-2023-0001.* The Board has again reviewed all of the MDE listed in the *Access Board Review of MDE Low Height and MSRP* and found two discrepancies in regard to Midmark podiatry chairs that were listed at 19 inches in the NPRM but are now listed at 21 inches on the manufacturer's website. The changes of these two heights to 21 inches instead of 19 inches does not change the overall conclusion that 17 inches is the appropriate height. Therefore, we adopt the evaluation in the 2023 MDE NPRM here for this final rule.

The Board reviewed information on individual products to determine what low height the product could achieve; it did not undertake a systematic review of every feature of each product to assess potential compliance with the MDE Standards. The level of specificity of publicly available information regarding each product varies by manufacturer and product line, limiting the ability to compare every feature of every product. Further, such a detailed study would be inappropriate at this point, given that the MDE Standards have no mandatory

application. For most of the products, the Board was able to find publicly available price information.

A number of online MDE suppliers listed both a manufacturer suggested retail price (MSRP) and discounted prices. As the actual price paid for a certain piece of medical equipment can vary widely depending on the supplier from which it is purchased and the type of contract a purchaser may have, the Access Board focused on the MSRP. The prices reported here are likely higher than the actual prices the MDE purchasers would pay, because purchasers typically pay less than MSRP due to special sales, volume discounts, or other reasons. The information the Board collected, including links to the public websites where the Access Board obtained the product and price information, is available in the *2023 Review of MDE Low Heights and MSRP. See Access Board Review of MDE Low Height and MSRP,* dated Dec. 5, 2023, *available at https://www.regulations.gov/docket/ATBCB-2023-0001.*

The Board relied on the suppliers' and manufactures' websites for its information collection, including photographs, schematics, and other specification lists and descriptions provided by the manufacturer or supplier online. The Board did not directly contact any manufacturers or suppliers to discuss their products.

Adjustable Height Exam Tables

The Access Board reviewed 28 adjustable exam tables currently on the market, 21 of which meet the current requirement with low heights within the 17-to-19-inch range. Of these 21 exam tables, five have a low height of 19 inches and an MSRP range of $5,923.01 to $12,74 2.00, or an average cost of $8,290.40; 16 exam tables have a low height of 18 inches and a MSRP range of $2,127.08 to $14,144, or an average cost of $4,635.11; and one exam table has a low height of 15.5 inches and a MSRP of $10,644. The other seven exam tables have low heights between 20 to 27 inches, falling outside of the current low transfer height requirement and have a MSRP range of $3,114.82 to $6,699.42, or an average cost of $4,173.33. The Board also reviewed 18 fixed height exam tables with a height range of 27 to 33 inches and a MSRP range of $548.90 to $3,966.38, with an average cost of $1,505.07.

In comparing the average MSRP of these adjustable exam tables, we found the difference between the one exam table that currently reaches below 17 inches and the average cost of exam tables in the 18-to-19-inch range to be a $5,138.58 difference. It would be an additional $1,332 if comparing the 15.5-inch exam table to exam tables that were adjustable but outside of the current MDE Standard low height range.

It is important to note that the Board did not evaluate them to determine if they comply with the other provisions of the MDE Standards, and given the large range of cost for exam tables within the 18-to-19-inch range ($2,127.08 to $14,144), it is difficult to ascertain the actual specific cost of moving from a low height range of 17 to 19 inches to a single specification of 17 inches. Additionally, the Board believes that with this final rule, other manufacturers will produce tables that reach a low height of 17 inches, which will cause the cost to decrease, as we saw an increase in lower exam table transfer heights since the promulgation of the original MDE Standards in 2017.

Adjustable Height Exam Chairs

The Board also reviewed specialized adjustable height exam chairs. Specifically, Obstetrics and Gynecological (OB–GYN) chairs, phlebotomy chairs, podiatry chairs, optometry/ophthalmology chairs, and dental chairs. Only the dental chairs met the requirement for a 17-inch low transfer height. Consequently, for the other types of chairs, we were not able to determine the approximate additional cost per unit that would be required to comply with this rule.

The Access Board reviewed three OB/GYN chairs, one of which has a low height of 22 inches and a MSRP of $3,450, and two which have a low height of 18 inches and 18.5 inches and a MSRP range of $3,972.67 to $5,470, with an average cost of $4,721.34. The Board also reviewed six fixed height OB–GYN chairs, finding a height range of 31 to 33 inches and a MSRP range of $543.82 to $2,624.08, with an average cost of $1,554.54.

The Board reviewed 12 phlebotomy chairs, two of which have low heights of 18 and 18.5 inches with a MSRP range of $1,199 to $2,249, and an average cost of $1,724. The other ten phlebotomy chairs have low heights from 20.25 inches to 22 inches and a MSRP range of $1,474 to $2,959, with an average cost of $2,05.64. The Board also reviewed 16 fixed height phlebotomy chairs, finding a height range from 18 to 26 inches with a MSRP range of $500 to $3,015.49, with an average cost of $1,432.98.

All 16 dental chairs that the Access Board reviewed have a low height of 19 inches or lower. Three of the chairs have a low height from 18 to 19 inches; however, the Board was only able to obtain the cost for one of these chairs, which is a refurbished price at $3,568. The other 13 chairs have a low height from 13.5 inches to 17 inches, with five having a low height below 14 inches. The Board was only able to ascertain an MSRP for six of these 13 chairs, which have an MSRP range from $5,598.00 to $9,490, with an average cost of $7,492.95. It is difficult to compare costs between these sets of dental chairs, as the only cost information the Board was able to obtain for a chair at 18 inches was a refurbished cost. However, based on the fact that the vast majority of dental chairs' low height was well below 17 inches and the other differences in the features of these chairs, low height doesn't appear to be a significant driver of cost difference for dental chairs.

The Access Board reviewed four podiatry chairs, two of which have a low height between 18 and 19 inches. For one of these podiatry chairs the Board was able to ascertain a MSRP of $15,241.38.[1] The other two podiatry chairs have a low height of 21–24 inches and a MSRP range of $4,995 to $11,299 or an average cost of $8,147.

Finally, the Board reviewed 11 optometry/ophthalmology chairs, all of which fall outside the current low height range. The seat height of these chairs ranged from 19.75 to 23 inches; the MSRP range was from $4,200 to $10,352; and the average cost was $6,073. However, the Board notes that since the original rulemaking a new type of optometry/ophthalmology chair has entered the market, which allows the examination chair to spin out of the way to permit patients in wheelchairs to move up to and use the equipment while remaining in their personal chairs. This examination chair with the accompanying stand for the equipment is $8,900, the chair alone is $4,650. This specific chair also provides a headrest, movable armrests and a chair the moves up and down and reclines, but the Board was unable to determine the low height. The Board acknowledges that for examinations where transfer is not necessary for a complete and accurate examination, such as an eye examination, there is a benefit to allowing patients to remain in their wheelchairs and avoid any potential for injury that accompanies transfer. In this situation the equipment would need to meet the requirements for diagnostic equipment used by patients seated in a wheelchair at M303. Enforcement authorities would need to address applicable specifications in the scoping

[1] The Board was unable to obtain a MSRP for the UMF Power Podiatry Chair, Model number 5015.

of an enforceable rule for dual use equipment that allows patients either to remain in their wheelchairs or to transfer to the examination chair. However, one possibility would be to exempt MDE from the low transfer height requirement where transfer is not required for examination.

VI. Regulatory Process Matters

A. Regulatory Planning and Review (Executive Orders 12866, 13563 and 14094)

The Access Board has examined the impact of this final rulemaking under Executive Orders 12866, 13563, and 14094. These Executive orders direct agencies to assess the costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). This final rule is a significant regulatory action within the meaning of Executive Order 12866, as amended by Executive Order 14094. *See* E.O. 14094 section 1(b), 88 FR 21879 (April 11, 2023) (defining ''significant regulatory action'' as, among other things, regulatory actions that have an annual effect on the economy of $200 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or Tribal governments or communities, or raise legal or policy issues for which centralized review would meaningfully further the President's priorities or the principles set forth in Executive Order 12866).

It is not possible to assess the costs or benefits of this rule with precision. The Board has analyzed the potential costs and benefits of a 17-inch low transfer height standard from a qualitative perspective, and the costs and benefits of an enforceable 17-inch low transfer height would depend in part on any scoping requirements that enforcement agencies might establish specifying the percentage of MDE that must be accessible. Unlike many of the Board's other rulemakings that provide minimum guidelines that enforcement agencies must adopt as minimum standards for accessibility, Section 510 of the Rehabilitation Act (the statutory provision under which the Board promulgated the MDE Standards) does not require enforcement agencies to adopt the technical criteria set forth in the MDE Standards as minimum standards or at all. Enforcement agencies must undertake their own cost/benefit analysis pursuant to Executive Order 12866 before they can adopt the MDE Standards—or portions thereof, such as the 17-inch low transfer height standard set forth in this rule—as enforceable requirements and establish scoping requirements. In the final regulatory impact analysis for the MDE Standards issued in 2017 (FRIA 2017), the Board explained that it was unable to estimate what costs (if any) manufacturers, providers, or others would incur as a result of the rule, or what level of social benefits would be accrued. *Available at https://www.access-board.gov/files/mde/mde-assessment.pdf.* Instead, that FRIA provided a brief overview of commonly used MDE in the current U.S. market to give a sense of how the technical requirements in the MDE Standards were or were not met among products being sold. *Id.* The FRIA 2017 analyzed the potential costs and benefits of the MDE Standards from a qualitative perspective. The change from a range of 17 to 19 inches to one specification of 17 inches would not have changed the analysis in the original FRIA, nor does the Access Board believe that finalizing this provision with a specification within the already proposed range would have an annual effect on the economy of $200 million or more. For this final rule the Access Board has followed the same methodology of analyzing the potential costs and benefits from a qualitative perspective.

The MDE FRIA 2017 reviewed the market cost of particular models of MDE but did not assess the cost of compliance with the MDE Standards. During our market research for the 2023 MDE NPRM and this final rule, we again looked at the cost of MDE on the market and also assessed the low transfer heights, when available on manufacturer or other third party websites; however, there were other differences in the MDE, beyond just a lower transfer height, so we are unable to attribute all of the cost difference to simply a lower transfer height. For example, we saw a wide range in the adjustable examination table market; tables with a low height of 18 to 19 inches had an MSRP range of $2,127 to $14,144. Currently, on the market there is one examination table that reaches a low transfer height below 17 inches, the Midmark 626 Barrier-Free examination chair, which reaches a low height of 15.5 inches and has an MSRP of $10,644. 2023 Access Board Review of MDE Low Height and MSRP *Available at https://www.regulations.gov/docket/ATBCB-2023-0001/document.*

The Board received a couple of comments in response to the questions posed regarding this regulatory assessment in the 2023 MDE NPRM. In Section 7 above, we summarize and address comments regarding cost and implementation time. Additionally, one commenter raised concerns about the data collected from manufacturer websites and asserted that the seat heights collected from company websites were marketing or advertised seat heights and not based on actual measurements. This commenter suggested the Access Board physically measure each product referenced in 2023 MDE NPRM document, *the Access Board Review of MDE Low Height and MSRP* to determine height. *Available at https://www.regulations.gov/document/ATBCB-2023-0001-0002.*

In creating the market review for the 2023 MDE NPRM and this final rule, the Access Board followed the same protocols that it relied on in the 2017 MDE FRIA, and again relied on publicly available information to determine the current status of MDE on the market. The Board relies on the information that manufacturers have put in their marketing specifications for the seat height of MDE for this assessment.

The benefits of establishing technical specifications for accessible MDE were well documented throughout the original MDE rulemaking process, including the extensive explanation in the Final Regulatory Analysis (FRIA 2017). *Available at https://www.access-board.gov/files/mde/mde-assessment.pdf.* These arguments continue to be valid today; as noted above, 60 percent of examination rooms still provide only a fixed-height table which is completely inaccessible to a person in a wheelchair.

In 2020, the National Council on Disability (NCD) issued a report titled Enforceable Accessible Medical Equipment Standards—A Necessary Means to Address the Health Care Needs of People with Mobility Disabilities. *Available at https://ncd.gov/publications/2021/enforceable-accessible-medical-equipment-standards.*

In this report, NCD describes the difficulty people with mobility disabilities still face in trying to access medical care. NCD explains that ''[a]dults with physical disabilities are at higher risk of foregoing or delaying necessary care and having unmet medical, dental, and prescription needs compared to adults without disabilities. Lack of timely access to primary and preventive care can result in the development of chronic and secondary conditions as well as exacerbation of the original disability condition itself, resulting in poorer health outcomes. Of

the 61 million people with disabilities in the United States, more than 20 million people over the age of 18 years have a disability that limits their functional mobility; this can pose challenges to accessing standard medical diagnostic equipment.'' *Id.* at 13. Further, NCD explains that ''[i]f patients are not transferred to an examination table, when it is clinically appropriate, it may be difficult if not impossible to conduct a comprehensive examination, which may lead to missed or delayed diagnosis.'' *Id.* at 17. NCD explains, and the Access Board concurs, that accessible MDE not only benefits the quality of care of patients with disabilities, but also impacts ''the occupational health and safety of health care workers, especially nurses and nursing assistants.'' *Id.* at 19. NCD notes that research is showing a relationship between musculoskeletal injuries and workers' compensation claims for health care professionals and safe patient handling, ''due in part to the overreliance on manual transfers to inaccessible equipment.'' *Id.*

While there are many provisions within the MDE Standards that address all aspects of the equipment, including the requirement for the ability to use a lift with the MDE (M301.4), to ensure that a person is able to be examined on the diagnostic equipment, the low transfer height selected should provide access to independent transfers to the largest percentage of people who use wheeled mobility devices that are capable of such a transfer. Independent transfer is safer for the patient and provides a safer environment for the health care provider in reducing the risk of injury during an assisted transfer.

As explained above in Dr. D'Souza's report, if the Board was to adopt a low transfer height of 19 inches, then between 39 to 42 percent of wheelchair users would not be able to effectuate a level transfer. However, by requiring a low height of 17 inches and high height of 25 inches and at least four other intermediate heights in between, the adjustable height transfer surface should be accessible to and usable by almost all (95 percent) of wheelchair users that can independently transfer.

The Board asserts that the benefits of establishing a low transfer height standard of 17 inches, both for the millions of Americans that use mobility devices and for the medical professionals and caregivers assisting those individuals transfer, outweighs the potential costs of establishing a low transfer height standard of 17 inches. Specifically, the Board finds that there is a significant need for accessible medical diagnostic equipment and that the safety of both the patient and caregiver are affected by ensuring as many individuals as possible who are capable of independent transfer are provided the opportunity to effectuate that transfer with a height specification for medical diagnostic equipment that is level to their current mobility device. These benefits, outweigh the costs of establishing a 17-inch low transfer height standard. However, as noted above, the Access Board has not assessed who would incur these potential costs and to what extent. Agencies considering whether to adopt the 17-inch transfer height as a requirement would be required to analyze the costs and benefits of doing so, including by assessing factors not included in the Access Board's analysis, such as the number of accessible devices required at facilities, when full compliance would be required, and whether covered entities would be allowed to rely on compliance with the 17- to 19-inch range for MDE procured during the pendency of the sunset provision and during any time thereafter. Therefore, the Access Board expects that if rulemaking agencies propose to adopt the 17-inch low transfer height standard as enforceable, they will carry out regulatory assessments that provide specific cost and benefit estimates relevant to their rules.

B. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) requires Federal agencies to analyze the impact of regulatory actions on small entities, unless an agency certifies that the rule will not have a significant impact on a substantial number of small entities. 5 U.S.C. 604, 605 (b). The MDE Standards do not impose any mandatory requirements on any entity, including small entities. Therefore, we did not prepare a final regulatory flexibility analysis.

C. Federalism (Executive Order 13132)

The Access Board has evaluated this final rule in accordance with the principles and criteria set forth in Executive Order 13132. We have determined that this action will not have a substantial direct effect on the States, the relationship between the Federal Government and the States, or on the distribution of power and responsibilities among the various levels of government, and, therefore, does not have federalism implications.

D. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (codified at 2 U.S.C. 1531 *et seq.*) (''UMRA'') generally requires that Federal agencies assess the effects of their discretionary regulatory actions that may result in the expenditure of $100 million (adjusted for inflation) or more in any one year by the private sector, or by state, local, and Tribal governments in the aggregate. The MDE standards do not impose any mandatory requirements on State, local, or Tribal governments or the private sector. Therefore, the Unfunded Mandates Reform Act does not apply.

E. Paperwork Reduction Act

Under the Paperwork Reduction Act (PRA), Federal agencies are generally prohibited from conducting or sponsoring a ''collection of information: as defined by the PRA, absent OMB approval. *See* 44 U.S.C. 3507 *et seq.* The MDE Standards do not impose any new or revised collections of information within the meaning of the PRA.

F. Congressional Review Act

This final rule is not a major rule within the meaning of the Congressional Review Act (5 U.S.C. 801 *et seq.*)

List of Subjects in 36 CFR Part 1195

Health care, Individuals with disabilities, Medical devices.

For the reasons stated in the preamble, and under the authority of 29 U.S.C. 794f, the Board amends 36 CFR part 1195 as follows:

PART 1195—STANDARDS FOR ACCESSIBLE MEDICAL DIAGNOSTIC EQUIPMENT

■ 1. The authority citation for part 1195 continues to read as follows:

Authority: 29 U.S.C. 794f.

■ 2. Amend appendix by:
■ a. Revising M301.2.1, paragraph A;
■ b. Removing and reserving M301.2.2;
■ c. Revising M302.2.1, paragraph A; and
■ d. Removing and reserving M302.2.2.

The revisions read as follows:

Appendix to Part 1195—Standards for Accessible Medical Diagnostic Equipment

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Chapter 3 * * *

M301 * * *

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M301.2.1 * * *

A. A low transfer position at a height of 17 inches (430 mm);

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M302 * * *

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M302.2.1 * * *

A. A low transfer position at a height of 17 inches (430 mm);

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Approved by vote of the Access Board on January 24, 2024.

Christopher Kuczynski,

General Counsel, U.S. Access Board.

[FR Doc. 2024–16266 Filed 7–24–24; 8:45 am]

BILLING CODE 8150–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 81

[EPA–R01–OAR–2024–0310; FRL–12108–01–R1]

Designations of Areas for Air Quality Planning Purposes; New York, New Jersey, Connecticut; New York-Northern New Jersey-Long Island, NY-NJ-CT 2015 8-Hour Ozone Nonattainment Area; Reclassification to Serious

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: Under the Clean Air Act (CAA or the ''Act''), the Environmental Protection Agency (EPA) is granting a request from the States of New York, New Jersey, and Connecticut to reclassify the New York-Northern New Jersey-Long Island, NY-NJ-CT ozone nonattainment area from ''Moderate'' to ''Serious'' for the 2015 8-hour ozone national ambient air quality standards (NAAQS). This action does not reclassify any areas of Indian country within the boundaries of this ozone nonattainment area.

DATES: This rule is effective on July 25, 2024.

ADDRESSES: EPA has established a docket for this action under Docket Identification No. EPA–R01–OAR–2024–0310. All documents in the docket are listed on the *https://www.regulations.gov* website. Although listed in the index, some information is not publicly available, *i.e.,* confidential business information (CBI) or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the internet and will be publicly available only in hard copy form. Publicly available docket materials are available at *https://www.regulations.gov,* at the U.S. Environmental Protection Agency, EPA Region 1 Regional Office, Air and Radiation Division, 5 Post Office Square—Suite 100, Boston, MA, and at the U.S. Environmental Protection Agency, EPA Region 2 Regional Office, Air Programs Branch, 290 Broadway, New York, New York 10007–1866. EPA requests that if at all possible, you contact the contact listed in the **FOR FURTHER INFORMATION CONTACT** section to schedule your inspection. The Regional Office's official hours of business are Monday through Friday, 8:30 a.m. to 4:30 p.m., excluding legal holidays and facility closures due to COVID–19.

FOR FURTHER INFORMATION CONTACT: For questions relating to Connecticut, contact Bob McConnell, Air and Radiation Division (Mail Code 5–MD), U.S. Environmental Protection Agency, Region 1, 5 Post Office Square, Suite 100, Boston, Massachusetts 02109–3912; (617) 918–1046, or by email at *mcconnell.robert@epa.gov,* and for questions relating to New York and/or New Jersey, contact Fausto Taveras, Environmental Protection Agency, Region 2, 290 Broadway, New York, New York 10007–1866, at (212) 637–3378, or by email at *Taveras.Fausto@epa.gov.*

SUPPLEMENTARY INFORMATION: Throughout this document whenever ''we,'' ''us,'' or ''our'' is used, we mean EPA.

Table of Contents

I. Reclassification of the New York-Northern New Jersey-Long Island, NY-NJ-CT Area to Serious Ozone Nonattainment

Effective August 3, 2018, the EPA classified the New York-Northern New Jersey-Long Island, NY-NJ-CT area under the CAA as ''Moderate'' for the 2015 8-hour ozone NAAQS. *See* 83 FR 25776 (June 4, 2018).This area is herein referred to as the NY-NJ-CT 2015 NAAQS nonattainment area. Classification of this area as a Moderate ozone nonattainment area established a requirement that the area attain the 2015 ozone NAAQS as expeditiously as practicable, but no later than six years from designation, *i.e.,* August 3, 2024. On May 23, 2024, the New Jersey Department of Environmental Protection requested that the EPA reclassify the NY-NJ-CT 2015 NAAQS nonattainment area from moderate to Severe, or, in the alternative, to Serious if the States of New York and Connecticut did not both submit requests to reclassify the area to Severe but did submit requests to reclassify this area to Serious. On June 5, 2024, the New York Department of Environmental Conservation (NYSDEC) requested that the NY-NJ-CT 2015 NAAQS nonattainment area be reclassified to Serious, and on June 13, 2024, the Connecticut Department of Energy and the Environment also submitted a request that the NY-NJ-CT 2015 NAAQS nonattainment area be reclassified to Serious.

We are approving these States' reclassification request under section 181(b)(3) of the Act, which provides for ''voluntary reclassification.'' Because the plain language of section 181(b)(3) mandates that we approve such a request, the EPA is granting the States' request for voluntary reclassification under section 181(b)(3) for the NY-NJ-CT 2015 NAAQS nonattainment area for the 2015 ozone NAAQS, and the EPA is reclassifying the area from Moderate to Serious. Because of this action, the NY-NJ-CT 2015 NAAQS nonattainment area must now attain the 2015 ozone NAAQS as expeditiously as practicable, but no later than nine years from the date of the initial designation as nonattainment, *i.e.,* August 3, 2027. Applicable SIP requirements and deadlines associated with the reclassification will be addressed in a separate notice.

Within the geographic boundaries of the NY-NJ-CT 2015 NAAQS nonattainment area Indian country exists under the jurisdiction of the Shinnecock Indian Nation. Because the State of New York does not have jurisdiction over Indian country located within its borders, NYSDEC's request to reclassify the NY-NJ-CT 2015 NAAQS nonattainment area does not apply to this area of Indian country. The EPA implements Federal CAA programs, including reclassifications, in Indian country consistent with our discretionary authority under sections 301(a) and 301(d)(4) of the CAA. The EPA has not received a reclassification request from any Tribe with jurisdiction within the NY-NJ-CT 2015 NAAQS nonattainment area. In this action, we are adding regulatory text to 40 CFR part 81 to indicate that the area under the jurisdiction of the Shinnecock Indian