

the reasons given for the publication of the interim final rule. In accordance with 5 U.S.C. 801(a)(1), VA will submit to the Comptroller General and to Congress a copy of this regulatory action and VA's Regulatory Impact Analysis.

#### Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100 million or more (adjusted annually for inflation) in any 1 year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

#### Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. This final rule will not have a significant economic impact on participating eligible entities and providers who enter into agreements with VA. To the extent there is any such impact, it will result in increased business and revenue for them. We also do not believe there will be a significant economic impact on insurance companies, as claims will only be submitted for care that will otherwise have been received whether such care was authorized under this Program or not. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604.

#### Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are as follows: 64.008—Veterans Domiciliary Care; 64.011—Veterans Dental Care; 64.012—Veterans Prescription Service; 64.013—Veterans Prosthetic Appliances; 64.014—Veterans State Domiciliary Care; 64.015—Veterans State Nursing Home Care; 64.024—VA Homeless Providers Grant and Per Diem Program; 64.026—Veterans State Adult Day Health Care; 64.029—Purchase Care Program; 64.035—Veterans Transportation Program; 64.038—Grants for the Rural Veterans Coordination Pilot; 64.039—CHAMPVA; 64.040—VHA Inpatient Medicine; 64.041—VHA Outpatient Specialty Care; 64.042—VHA Inpatient Surgery; 64.043—VHA Mental Health Residential; 64.044—VHA Home Care;

64.045—VHA Outpatient Ancillary Services; 64.046—VHA Inpatient Psychiatry; 64.047—VHA Primary Care; 64.048—VHA Mental Health Clinics; 64.049—VHA Community Living Center; 64.050—VHA Diagnostic Care.

#### List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Government contracts, Grant programs-health, Grant programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Mental health programs, Nursing homes, Reporting and recordkeeping requirements, Travel and transportation expenses, Veterans.

#### Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Gina S. Farrisee, Deputy Chief of Staff, Department of Veterans Affairs, approved this document January 12, 2018, for publication.

Dated: May 8, 2018.

#### Consuela Benjamin,

*Regulations Development Coordinator, Office of Regulation Policy & Management, Office of the Secretary, Department of Veterans Affairs.*

#### PART 17—MEDICAL

■ Accordingly, the interim rules amending 38 CFR part 17 which were published at 80 FR 74991 on December 1, 2015, and 81 FR 24026 on April 25, 2016, are adopted as final without change.

[FR Doc. 2018–10054 Filed 5–10–18; 8:45 am]

BILLING CODE 8320–01–P

#### DEPARTMENT OF VETERANS AFFAIRS

#### 38 CFR Part 17

#### RIN 2900–AQ06

#### Authority of Health Care Providers To Practice Telehealth

**AGENCY:** Department of Veterans Affairs.  
**ACTION:** Final rule.

**SUMMARY:** The Department of Veterans Affairs (VA) is amending its medical regulations by standardizing the delivery of care by VA health care providers through telehealth. This rule ensures that VA health care providers can offer the same level of care to all

beneficiaries, irrespective of the State or location in a State of the VA health care provider or the beneficiary. This final rule achieves important Federal interests by increasing the availability of mental health, specialty, and general clinical care for all beneficiaries.

**DATES:** This final rule is effective June 11, 2018.

#### FOR FURTHER INFORMATION CONTACT:

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**SUPPLEMENTARY INFORMATION:** In a document published in the **Federal Register** on October 2, 2017, VA proposed to amend its medical regulations by standardizing the delivery of health care by VA health care providers through telehealth. 82 FR 45756. VA provided a 30-day comment period, which ended on November 1, 2017. We received 75 comments on the proposed rule.

Section 7301 of title 38, United States Code (U.S.C.), establishes the general functions of the Veterans Health Administration (VHA) within VA, and establishes that its primary function is to “provide a complete medical and hospital service for the medical care and treatment of veterans, as provided in this title and in regulations prescribed by the Secretary [of Veterans Affairs (Secretary)] pursuant to this title.” See 38 U.S.C. 7301(b). The Secretary is responsible for the proper execution and administration of all laws administered by the Department and for the control, direction, and management of the Department, including agency personnel and management matters. See 38 U.S.C. 303. To this end, Congress authorized the Secretary “to prescribe all rules and regulations which are necessary or appropriate to carry out the laws administered by the Department and are consistent with those laws.” See 38 U.S.C. 501(a). The Under Secretary for Health is directly responsible to the Secretary for the operation of VHA. See 38 U.S.C. 305(b). Unless specifically otherwise provided, the Under Secretary for Health, as the head of VHA, is authorized to “prescribe all regulations necessary to the administration of the Veterans Health Administration,” subject to the approval of the Secretary. See 38 U.S.C. 7304.

To allow VA to carry out its medical care mission, Congress also established a comprehensive personnel system for certain VA health care providers, independent of the civil service rules.

See 38 U.S.C. chapters 73–74. Congress granted the Secretary express statutory authority to establish the qualifications for VA's health care providers, determine the hours and conditions of employment, take disciplinary action against employees, and otherwise regulate the professional activities of those individuals. See 38 U.S.C. 7401–7464.

To be eligible for appointment as a VA employee in a health care position covered by 38 U.S.C. 7402(b) (other than a medical facility Director appointed under section 7402(b)(4)), a person must, among other requirements, be licensed, registered, or certified to practice his or her profession in a State. The standards prescribed in section 7402(b) establish only the basic qualifications necessary “[t]o be eligible for appointment” and do not limit the Secretary or Under Secretary for Health from establishing other qualifications for appointment, or additional rules governing such personnel. In particular, section 7403(a)(1) provides that appointments under chapter 74 “may be made only after qualifications have been established in accordance with regulations prescribed by the Secretary, without regard to civil-service requirements.” Such authority is necessary to ensure the viability of our national health care system, which is designed to ensure the well-being of those who have “borne the battle.”

Just as it is critical to ensure there are qualified health care providers on-site at all VA medical facilities, VA must ensure that all beneficiaries, specifically including beneficiaries in remote, rural, or medically underserved areas, have the greatest possible access to mental health care, specialty care, and general clinical care. Thus, VA developed a telehealth program as a modern, beneficiary- and family-centered health care delivery model that leverages electronic information or telecommunication technologies to support clinical health care, patient and professional health-related education, public health, and health administration, irrespective of the State or location within a State where the health care provider or the beneficiary is physically located at the time the health care is provided. Telehealth enhances VA's capacity to deliver essential and critical health care services to beneficiaries located in areas where certain health care providers may be unavailable or to beneficiaries who may be unable to travel to the nearest VA medical facility for care because of their medical conditions. By providing health care services by telehealth from one State to a beneficiary located in

another State or within the same State, whether that beneficiary is located at a VA medical facility or in his or her own home, VA can use its limited health care resources most efficiently.

Congress has required other Departments and agencies to conduct telehealth programs. See, e.g., Public Law 114–328, sec. 718(a)(1) (“the Secretary of Defense shall incorporate, throughout the direct care and purchased care components of the military health system, the use of telehealth services”). While VA does not have an analogous mandate, several statutes confirm that Congress intends for VA to operate a national health care system for beneficiaries that includes telehealth. Congress has required the Secretary “to carry out an initiative of teleconsultation for the provision of remote mental health and traumatic brain injury assessments in facilities of the Department that are not otherwise able to provide such assessments without contracting with third-party providers or reimbursing providers through a fee basis system.” See 38 U.S.C. 1709A(a)(1). Congress has authorized the Secretary to “waive the imposition or collection of copayments for telehealth and telemedicine visits of veterans under the laws administered by the Secretary.” See 38 U.S.C. 1722B. And, as recently as December 2016, Congress required VA to initiate a pilot program to provide veterans a self-scheduling, online appointment system; this pilot program must “support appointments for the provision of health care regardless of whether such care is provided in person or through telehealth services.” See Public Law 114–286, sec. 3(a)(2).

In an effort to furnish care to all beneficiaries and use its resources most efficiently, VA needs to operate its telehealth program with health care providers who will provide services via telehealth to beneficiaries in States in which they are not located, licensed, registered, certified, or otherwise authorized by the State. Without this rulemaking, doing so may jeopardize these providers' credentials, including fines and imprisonment for unauthorized practice of medicine, because of conflicts between VA's need to provide telehealth across the VA system and some States' laws or requirements for licensure, registration, certification, that restrict the practice of telehealth. A number of States have already enacted legislation or regulations that restrict the practice of interstate telehealth.

This final rulemaking clarifies that VA health care providers may exercise their authority to provide health care

through the use of telehealth, notwithstanding any State laws, rules, licensure, registration, or certification requirements to the contrary. In so doing, VA is exercising Federal preemption of conflicting State laws relating to the practice of health care providers; laws, rules, regulations, or other requirements are preempted to the extent such State laws conflict with the ability of VA health care providers to engage in the practice of telehealth while acting within the scope of their VA employment. Preemption is the minimum necessary action for VA to furnish effective telehealth services because it would be impractical for VA to lobby each State to remove any restrictions that impair VA's ability to furnish telehealth services to beneficiaries and then wait for the State to implement appropriate changes. That process would delay the growth of telehealth services in VA, thereby delaying delivery of health care to beneficiaries. It would be costly and time-consuming for VA and would not guarantee a successful result. We note that, apart from the limited action of authorizing telehealth across and within jurisdictions in furtherance of important Federal interests, this rulemaking does not expand the scope of practice for VA health care providers beyond what is required or authorized by Federal law and regulations or as statutorily defined in the laws and practice acts of the health care provider's State of licensure. Additionally, this rulemaking does not affect VA's existing requirement that all VA health care providers adhere to restrictions imposed by their State license, registration, or certification regarding the professional's authority to prescribe and administer controlled substances. To further clarify this point, we have changed subsection (b) to clearly state that this section does not otherwise grant health care providers additional authorities that go beyond what is required or authorized by Federal law and regulations or as defined in the laws and practice acts of the health care providers' State license, registration, or certification. This is simply a clearer statement of the policy articulated in the proposed rule, but is being added because of the public comments we received expressing differing views on this matter.

For these reasons, VA is establishing a new regulation, 38 CFR 17.417, that authorizes VA health care providers to treat beneficiaries through telehealth irrespective of the State, or of the location in a State, of the VA health care provider or the beneficiary.

Most of the comments that were received on the proposed rule support

the rule and are summarized as follows. We received several comments supporting the rule saying that it would increase access to health care, specifically for those beneficiaries who live in rural and medically underserved areas who are not able to go to a VA medical facility either because of their location or their medical conditions. We also received many comments in support of the rule stating that telehealth has been shown to improve clinical outcomes and would improve the quality of care at VA. The commenters stated that the telehealth program would be successful in treating beneficiaries with a variety of conditions, including respiratory conditions, cardiovascular conditions, psychotherapy, post-traumatic stress disorder, traumatic brain injuries, Parkinson's disease, multiple sclerosis, vision loss, sleep disorders, and audiological conditions. One commenter summarized key clinical studies demonstrating the benefits of telehealth technologies. Similarly, commenters stated that more convenient access to health care would result in more personalized care, more engagement by beneficiaries and their caregivers, better health outcomes, and an improved quality of life. Several commenters stated that the proposed rule would help streamline health care for veterans and would facilitate modern, beneficiary and family centered health care.

In addition to the benefits for VA beneficiaries, many commenters supported the rule because it would benefit VA more generally and VA's health care providers. A commenter supported the rule, saying that it would protect health care providers while they are practicing within the scope of their VA employment. Multiple commenters supported the rule citing its cost effectiveness. In addition, a commenter said that it would result in shorter appointments for patients and physicians and would also decrease appointment no-show rates. Other commenters said that the rule would reduce the use and cost of transportation, save beneficiaries and their caregivers hours of their time and lost wages, result in hospital cost savings through decreased emergency room and hospital visits, and increase local revenues for laboratories and pharmacies. In addition, multiple commenters supported the rule stating that State licensing barriers hindered telehealth and that it was necessary to remove artificial and geographic State barriers. A commenter also stated that they supported the proposed rule

because it would provide opportunities for the medical students and residents who train at VA to become familiar with telehealth and be exposed to its optimal uses.

Several commenters supported the rule because it did not include contract physicians. In particular, one commenter stated that contract physicians are not subject to the same accountability, oversight, training, and quality control as those employed directly by VA. We are not making any edits based on these positive comments.

In addition to the previously discussed comments supporting the rule, the Federal Trade Commission (FTC) also submitted a supportive comment. Specifically, the FTC said that the rule would likely increase access to telehealth services, increase the supply of telehealth providers, increase the range of choices available to patients, improve health care outcomes, reduce long-term costs by reducing hospitalizations and treatment of advanced disease, and reduce travel costs incurred by VA. The rule would also enhance price and non-price competition and improve the ability of VA to compete more effectively by hiring qualified providers and reducing VA's health care costs. FTC also stated that the rule would provide an important example to non-VA health care providers, state legislatures, employers, patients, and others of telehealth's potential benefits and may spur innovation among other health care providers and, thereby, promote competition and improve access to care. In addition, FTC stated that the rule may afford a valuable opportunity to gather data and provide additional evidence for VA and outside policymakers to assess the effects of telehealth expansion, thereby benefitting VA beneficiaries and health care consumers generally. We are not making any edits based on these comments.

We received multiple comments that favored VA's proposed rule and that focused on how VA could utilize specific commercially available software and company products. The commenters believed that these products could improve the telehealth services described in the proposed rule. We appreciate the commenters' suggestions and innovative solutions, but these comments are beyond the scope of the proposed rule, which does not address the specific technology or platforms VA uses in furnishing telehealth. We are not making any edits based on these comments.

A commenter was in support of the proposed rule but added that the rule

should extend to all VA-funded health services. The proposed rule only addressed the protection of VA health care providers while providing telehealth services within the scope of their VA employment. We do not believe it is prudent or necessary at this time to include contract providers within the scope of this rule. We are not making any edits based on this comment.

A commenter supported the rule, but indicated that VA should have a mechanism in place to monitor the overall satisfaction and health of the beneficiaries who receive care via telehealth. VA is committed to ensuring that beneficiaries receive high quality health care. VA has controls in place to continuously monitor the health care provided by all VA health care providers, including telehealth providers. This rule will not affect the quality of the health care provided or the internal controls currently in place. We are not making any edits based on this comment.

Several commenters indicated that the rule should be extended to cover health care providers who participate in the Veterans Choice Program, authorized by section 101 of the Veterans Access, Choice, and Accountability Act of 2014 or other health care furnished by non-Department providers. Similarly, another commenter said that the rule restricts VA "regarding contracting with an outside entity that may be able to fill a need through Choice or any other community care program." The commenter stated that VA can ensure that a contractor meets the full standard of VA appointees by requiring that the contractor be a VA appointee and requiring that the contractor meet the licensure and credentialing requirements of 38 U.S.C. 7402(b).

VA acknowledges that the rule does not provide the same protection for community health care providers furnishing care for VA, including health care providers who participate in the Choice Program, as it does for VA health care providers. The proposed rule stated that a health care provider must be appointed by VA and cannot be a VA-contracted health care provider. Community health care providers may practice telehealth; however, they would be required to adhere to their individual State license, registration, or certification requirements and would not be otherwise covered by this rule. We do not believe it is prudent or necessary at this time to include contract providers within the scope of this rule. Additionally, contractors are not given an appointment to VA; only employees are given appointments. To

further clarify this point, we have changed subsection (a)(2)(iv) to clearly state that this section does not apply to VA-contracted health care providers. This is simply a clearer statement of the policy articulated in the proposed rule, but is being added because of the public comments in which there is confusion as to whether a contractor is a VA employee. Finally, community providers may be unable or unwilling to furnish telehealth across State lines. The Federal Tort Claims Act (FTCA) would cover VA providers in the event of a malpractice claim, but FTCA does not cover community providers. It is unclear whether or not the insurers or State level tort claims acts would cover community providers in the case of malpractice. We are not making any other edits based on these comments.

A commenter stated that VA should pay physicians under the Veterans Choice Program at or above the Medicare rate, and that VA should include rural health clinics in the Veterans Choice Program. These issues are related to administration of the Veterans Choice Program and not to this rule, which governs VA employees' authority to practice telehealth. This comment is, therefore, beyond the scope of the proposed rule. We are not making any edits based on this comment.

Several commenters indicated that VA should take further efforts to combat States' laws restricting telehealth. We stated in the proposed rule that it would be "impractical for VA to lobby each State to remove its restrictions that impair VA's ability to furnish telehealth services to beneficiaries and then wait for the State to implement appropriate changes." We understand the commenters' concerns and agree that having equitable State laws relating to telehealth would be ideal. However, such action is beyond the scope of this rulemaking. We are not making any edits based on these comments.

Several commenters were in favor of the rule but stated that registered nurses, nurse practitioners, physician assistants, and advanced practice registered nurses should be allowed to practice to the full extent of their clinical education, training, and national certificates. Several commenters also indicated that VA should prohibit the supervision of certified registered nurse anesthetist services from being included as part of the expansion of telehealth services in VA. The granting of full practice authority to certain advanced practice registered nurses has already been addressed via rulemaking. See 38 CFR 17.415 and 81 FR 90198. Moreover, the proposed rule only addressed the types

of settings where VA health care providers could provide telehealth services and established that all VA health care providers may be allowed to practice telehealth. As previously said in this rulemaking, the proposed rule does not expand VA health care providers' authority beyond what is required or authorized by Federal law and regulations or as defined in the laws and practice acts of the health care provider's State of licensure. Any changes except preempting State laws, rules, regulations and requirements that restrict VA's telehealth authority are beyond the scope of the proposed rule. We are not making any edits based on these comments.

One commenter was concerned that health care providers would not be protected under their medical malpractice insurance plans. This rulemaking will allow VA to better protect its health care providers who practice telehealth within the scope of their VA employment, regardless of conflicting State laws or regulations. The FTCA is the exclusive remedy "for damages for personal injury, including death, allegedly arising from malpractice or negligence of a health care employee of the [Veterans Health] Administration in furnishing health care or treatment while in the exercise of that employee's duties in or for the Administration." See 38 U.S.C. 7316. Subsection (c) of the statute provides in part: "Upon a certification by the Attorney General that the defendant was acting in the scope of such person's employment in or for the Administration at the time of the incident out of which the suit arose, any such civil action or proceeding commenced in a State court shall be . . . deemed a tort action brought against the United States under the provisions of title 28 and all references thereto." VA health care providers would, therefore, be protected from personal liability while providing care within the scope of their VA employment, including the provision of telehealth services. We are not making any edits based on this comment.

Several commenters were concerned that a health care provider would not be protected from all individual actions by the State against the provider's license, registration, or certification by the proposed rule. Another commenter indicated that a health care provider would be engaged in unauthorized health care practice unless the provider was licensed, registered, or certified in the State where they practice. As we said in the proposed rule, "VA would exercise Federal preemption of State licensure, registration, and certification

laws, rules, regulations, or requirements to the extent such State laws conflict with the ability of VA health care providers to engage in the practice of telehealth while acting within the scope of their VA employment." We also said that "in circumstances where there is a conflict between Federal and State law, Federal law would prevail in accordance with Article VI, clause 2, of the U.S. Constitution (Supremacy Clause)." Therefore, VA health care providers are protected by this final rule from any actions by individual States or State licensing boards to enforce a State law, rule, regulation or requirement while VA health care providers are practicing telehealth within the scope of their VA employment. We are not making any edits based on these comments.

A commenter strongly supported States' ability to regulate the practice of telehealth within their State, saying that "only physicians and surgeons licensed in [a State] should be allowed to practice medicine in [in that State], in order to ensure the highest quality medical care is being provided to health care consumers." The commenter further said that the proposed rule "would undermine [the State's] ability to protect health care consumers, as the Board will have no ability to discipline VA providers that are licensed in another state and providing telehealth outside of a VA facility in [that State], as they do not hold a license to practice medicine in [their State]." VA disagrees that this rulemaking will undermine the States' abilities to protect their health care consumers. VA has robust requirements for disciplining providers who fail to provide adequate health care, which includes reporting that provider to his or her licensing board, if applicable. We are not making any edits based on this comment.

One commenter recommended that VA work to improve the system for investigating, removing, and reporting bad providers to State licensing boards and also recommended that this be part of the policy that would implement this rulemaking. Another commenter also expressed concern that if a State cannot discipline a physician practicing medicine within its borders, it undermines the medical licensure system. VA currently has a system in place for reporting health care providers to State licensing boards whose behavior or clinical practice so substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients. VA continues to work closely with State licensing boards to further improve the reporting of VA

health care providers who have failed in VA's mission of providing safe care to its beneficiaries. Patients would still have the ability to file a tort claim and States would still have ability to prosecute for criminal offenses. However, this rulemaking only focuses on the expansion of VA telehealth services and only prohibits States from taking actions to enforce a State law, rule, regulation or requirement against VA health care providers while practicing telehealth. We are not making any edits based on these comments.

One commenter indicated that telehealth may not be the appropriate means of delivering health care to beneficiaries with some mental health conditions. Another commenter said that telehealth would not benefit homeless beneficiaries who suffer from mental conditions. We agree with the commenters that telehealth may not be the most appropriate means for the delivery of health care for all beneficiaries. However, health care providers and beneficiaries will have the opportunity to determine the best treatment option for the delivery of health care in each individual situation. We also agree that the delivery of health care via telehealth in a beneficiary's home may not be a viable means of health care for a homeless beneficiary. However, homeless beneficiaries may still benefit from telehealth visits from their local VA medical facility. A homeless beneficiary can be seen in a VA medical facility and be treated for his or her health condition from a health care specialist who is remotely performing the health care visit from another VA medical facility. We are not making any edits based on these comments.

Several commenters were concerned that the health care provider would rely on verbal communication and not be able to observe symptoms such as manic behaviors, tremors, cuts, bruises, or other possible signs of self-imposed injuries that would have otherwise been visible in an in person exam. A commenter said that health care providers would get a limited medical history by examining a beneficiary via telehealth, especially if the beneficiary has comorbidities and addictions that may not be obvious via telehealth. The commenter further said that beneficiaries could be misdiagnosed and some health care conditions missed if the beneficiary was only seen via telehealth. Another commenter said that a face to face interview helps a health care provider gain a better rapport with a patient. Another commenter was also concerned that the continuity of health care would be affected because the

primary care provider would not have access to the telehealth records and thus be presented with an incomplete medical history of the patient. This would especially be detrimental if the beneficiary had been prescribed medications during the telehealth visit. The commenter indicated that the beneficiary would receive a lower quality of care via telehealth than what they would have received in an in-person health care visit. Another commenter said that the use of telehealth for eye care services should not substitute the benefits of an in-person eye examination. This rulemaking authorizes VA providers to offer telehealth services as an option for beneficiaries irrespective of the location of the health care provider or the beneficiary. The rule enhances the accessibility of VA health care by providing beneficiaries an additional option through which they can engage in the health care system. The rule does not create a requirement for service delivery through telehealth; instead, it empowers health care providers and beneficiaries to choose when telehealth is appropriate. VA believes that the health care provider and the beneficiary are in the best position to make decisions about the risks and benefits of any health care decision and will ultimately decide the best option for the delivery of such care. Also, VA health care providers will have access to a beneficiary's health record during a telehealth visit and the telehealth visit will become part of the health record. We are not making any edits based on these comments.

Several commenters questioned the privacy of the beneficiary when video-conferencing was used. The commenters were concerned that the telehealth visit would be intercepted by a third party, which would violate the beneficiary's privacy. A commenter was also concerned that putting the beneficiary's information on an online database would give rise to Health Insurance Portability and Accountability Act (HIPAA) and security concerns. Another commenter said that the proposed rule did not "identify security standards or other requirements VA health care providers are expected to abide by when providing services via telehealth." Information security and privacy are critical priorities for VA. The Veterans Health Administration, and its telehealth program, work hand in hand with the VA Office of Information Technology and Information Security when implementing telehealth programs. Equipment, software, and process choices are made to mitigate

security risks and ensure adherence to the Federal Government's stringent information security and privacy requirements, including standards defined by the Federal Information Security Management Act, the National Institute of Standards and Technology, the Privacy Act, and HIPAA. As an example of one measure to protect privacy, clinical video data is encrypted to mitigate the risk of third party interception during video visits. Beneficiary data will not be stored outside VA, nor will it persist on the beneficiary's device following the telehealth session. All VA employees, including health care providers, have to adhere to the privacy and security standards implemented by VA. We are not making any edits based on these comments.

Another commenter strongly felt that beneficiaries should be seen in-person at least once before being prescribed medication, including controlled substances. Several commenters encouraged VA to establish an interagency working group between VA, the Food and Drug Administration, and the Drug Enforcement Administration (DEA) to ensure that beneficiaries have safe access to care by modernizing rules regarding advanced practice registered nurses prescriptive authority. The proposed rule said that the rule "does not affect VA's existing requirement that all VA health care providers adhere to restrictions imposed by their State license, registration, or certification regarding the professional's authority to prescribe and administer controlled substances." We also said in the proposed rule that health care providers will continue to be subject to the limitations "imposed by the Controlled Substances Act, 21 U.S.C. 801, *et seq.*, on the authority to prescribe or administer controlled substances, as well as any other limitations on the provision of VA care set forth in applicable Federal law and policy." Any change to the Controlled Substances Act or the creation of a working group is outside the scope of the proposed rule. We are not making any edits based on these comments.

One commenter was concerned that there might be insurance fraud on the part of health care providers who practice in one State and deliver health care services via telehealth in another State. VA health care providers would not directly engage in third party insurance claims. Moreover, billing is beyond the scope of this rulemaking. We are not making any edits based on this comment.

Another commenter said that VA does not allow for "potential and applicable

copayments and deductibles to be collected at the time of service for eligible veterans receiving care or services.” The commenter finds that not allowing this type of copayment collection is “unworkable and contrary to medical office billing practices.” We stated in the Supplementary Information paragraph of the proposed rule that “Congress has authorized the Secretary to “waive the imposition or collection of copayments for telehealth and telemedicine visits of veterans under the laws administered by the Secretary.” See 38 U.S.C. 1722B.” Also, under 38 CFR 17.108(e)(16), in-home video telehealth care is not subject to the collection of copayments. We are not making any edits based on these comments.

Several commenters expressed concern that beneficiaries may not have access to a computer or the internet. The commenters were concerned that these beneficiaries would not be able to access health care via telehealth because of the lack of technology in the beneficiary’s home. Another commenter was concerned that there might be potential connectivity issues in rural areas due to limited access to broadband internet. A commenter questioned whether VA would assist a beneficiary in setting up the telehealth services or provide financial assistance for the equipment or internet access. A commenter requested that VA clarify whether electronic information or telecommunications technologies includes video conferencing and telephone. VA continues to look into solutions to resolve technical difficulties in its expansion of telehealth services. This rulemaking addresses one critical barrier to standardizing service availability via telehealth, inclusive of video conferencing, telephone, and other telecommunication technologies, but does not address all barriers, including the access to technology. We are not making any edits based on these comments.

A commenter questioned how the proposed rule would be affected by another proposed rule on Prosthetic and Rehabilitative Items and Services and how this other rule would impact telehealth service provision of certain equipment and services. The proposed rule does not address how VA would provide equipment used in telehealth visits. The provision of telehealth equipment is beyond the scope of the proposed rule. We are not making any edits based on this comment.

A commenter asked whether VA would offer “cyber-clinical rooms” in VA medical facilities to provide telehealth services. Where beneficial,

VA will equip space for telehealth assessments. We are not making any edits based on this comment.

One commenter questioned how the beneficiary will know if telehealth is available to them for their health care needs. As previously said in this final rule, telehealth enhances the accessibility of VA health care by providing beneficiaries an additional option through which they can engage in the VA health care system. The rulemaking leaves the discussion about the health care modality chosen to the health care provider and the beneficiary. Also neither this final rule nor the proposed rule prescribe the details of how the telehealth program will be further implemented. We are not making any edits based on this comment.

One commenter was concerned that the proposed rule did not address how a “potential emergent situation would be addressed in situations where neither party is located at a VA medical center or other clinical site especially if the telehealth encounter occurs across state lines.” The commenter stressed that VA should evaluate its protocols on telehealth to ensure continued patient safety, including having a back-up plan in case of an emergent situation, identifying a family member or other individual as a point of contact if the beneficiary experiences a crisis, and other types of local assistance for the beneficiary. VA has standard guidance to address emergent situations when providers and beneficiaries are not located at a VA medical facility or other clinical site, including when the telehealth visit occurs across State lines. A specific example of emergency management guidance is that health care providers are trained to have emergency contact information at the onset of video appointments for use in the event of an emergency. We are not making any edits based on this comment.

One commenter expressed multiple concerns with the proposed rule. The commenter expressed concern that technology is necessary to utilize telehealth and that some beneficiaries may not want to use the technology while others may not be able to. The commenter felt that it was not fair to give beneficiaries the opportunity to have more access to health care by a means that they do not know how to use or do not want to use. We reiterate that the health care provider and the beneficiary will determine whether telehealth is appropriate in each individual situation; VA will not require telehealth. While we acknowledge the commenter’s concern, VA believes that

the health care provider and the beneficiary are in the best position to make decisions about the risks and benefits of any health care decision and will ultimately decide the best option for the delivery of such care. Moreover, allowing willing beneficiaries to participate in telehealth should increase the availability of in-person visits for those beneficiaries who prefer that option.

Second, the commenter questioned authority VA has to override the State laws. The commenter said that in the absence of a specific mandate by Congress, this rule is an arbitrary agency action. The commenter explained that the Non-Delegation Doctrine prohibits Congress from delegating legislative powers to Federal agencies and that the Federal agency can only use those powers that Congress has chosen to give them in an enabling act. The commenter cited Executive Order 13132 and quoted portions from Section 4(a) and 4(c). Specifically, the commenter said, “[t]here has to be a federal statute that: ‘contains an express preemption provision or . . . some other clear evidence that Congress intended preemption of State law’. It follows: ‘Any regulatory preemption of State law shall be restricted to the minimal level necessary . . .’”

VA disagrees that we lack authority for this action. As explained in the proposed rule, Section 4(b) of Executive Order 13132 allows agencies to preempt State law so long as the exercise of State authority conflicts with the exercise of Federal authority under the Federal statute.

Here, the exercise of a State’s authority directly conflicts with the exercise of Federal authority under the Federal statute. Specifically, a State rule limiting telehealth directly conflicts with VA’s authority under 38 U.S.C. 7401–7464 to establish the qualifications for VA’s health care providers and otherwise regulate the professional activities of those individuals (*i.e.*, allow its health care providers to practice telehealth anywhere). As previously mentioned in this rulemaking, Congress has required the Secretary “to carry out an initiative of teleconsultation for the provision of remote mental health and traumatic brain injury assessments in facilities of the Department” and has otherwise required or authorized the use of telehealth by VA. See, *e.g.*, 38 U.S.C. 1709A(a)(1).

As to the commenter’s citation to Section 4(c) of Executive Order 13132, which limits pre-emption to the minimum level needed to achieve the objectives of the statutes, VA believes

that this final rule is restricted to the minimum level necessary to support its telehealth program. In particular, VA explicitly limited the scope of the rule to only allow its health care providers to practice telehealth anywhere. VA did not expand the scope of the rule to more generally allow its health care providers to practice beyond what is required or authorized by Federal law and regulations or as defined in the laws and practice acts of the health care provider's State of licensure, registration or certification.

Finally, the commenter said that the Veterans E-Health and Telemedicine Support (VETS) Act of 2017 was introduced into the United States Senate in April 2017 and that it had not been approved by Congress or signed by the President. The commenter did not request that any changes be made to the regulation in light of the proposed legislation, nor did the commenter say that the final rule should not be published as a result of the proposed legislation. While legislative action would resolve any ambiguity as to VA's authority in this matter, the introduction of a piece of legislation is not evidence that VA does not already have authority in this area. VA has adequate authority for this rulemaking as described above and in the proposed rule. We make no edits to the rule based on this comment.

Another commenter expressed concern that this rule was being implemented without clear direction from Congress and with an abbreviated comment period. As previously explained, an express mandate from Congress is not necessary for VA to regulate on this topic. In addition, although the period for public comment for this rule was 30 days instead of 60 days, VA determined that it was against public interest and the health and safety of VA beneficiaries to have the 60 day comment period, for the reasons specified in the proposed rule. Moreover, in compliance with Executive Order 13132 (Federalism), VA officially started consulting with State officials on July 12, 2017, well over 60 days prior to the publication of the rule. Therefore, the stakeholders most invested in the rule had more than 3 months to provide feedback to VA, and the majority of their comments supported the rule.

The commenter also said that specific clarifications and additions are necessary to the rule. The commenter listed five criteria: (1) The standard of care must remain the same regardless of whether the services are provided via telehealth or in person; (2) eye and vision telehealth services cannot replace an in-person comprehensive eye

examination; (3) the use of eye and vision telehealth may be appropriate for only certain uses that may be extended as new technologies are made available; (4) the use of eye and vision telehealth is not appropriate for establishing the doctor-patient relationship, for initial diagnosis, as a replacement for recommended face-to-face interactions, or as a replacement for partial or entire categories of care; and (5) screening for specific or groups of eye health issues using telehealth for direct-to-patient eye and vision-related applications should not be used to diagnose eye health conditions or as a replacement or replication for a comprehensive dilated eye examination. VA appreciates the commenter's specific suggestions for when telehealth is most appropriate for vision and eye care; however, the commenter's request for clarification is beyond the scope of this rulemaking. This rulemaking does not establish requirements for when telehealth will be used nor does it establish criteria that must be met for a beneficiary to seek health care via telehealth. Instead, this rulemaking allows VA health care providers to practice telehealth regardless of their location or the location of the beneficiary. VA will make determinations on when the use of telehealth (*i.e.*, vision/eye care and the like) will be appropriate outside of this rule. As such, the commenter's requested suggestions are beyond the scope of the rulemaking.

Similarly, the commenter expressed concern regarding the standard of care and how to best ensure patient safety when telehealth is used. The commenter provided examples of how various jurisdictions addressed this concern. The commenter also said that a "one-size-fits-all approach" would be a step backwards and that at any point in the diagnosis and care continuum the patient should have the right to choose in-person care. The commenter recommended that VA ensure that all beneficiaries are aware that they can choose between telehealth or in-person care at any point. To ensure beneficiaries are apprised of their rights, the commenter recommended that VA require beneficiaries to sign an informed consent form. VA reiterates that this rulemaking is narrowly tailored to clarify the authority of VA health care providers to practice telehealth within the scope of their VA employment. The rulemaking does not establish the criteria for beneficiaries to participate in the telehealth program nor does it authorize a lower standard of care for patients who choose to receive service via telehealth. Accordingly, the

commenter's suggestions are beyond the scope of the rule.

The commenter also said that, in the absence of a true mandate by Congress, it is critical that VA consider the most recent statutory actions from Congress related to telehealth. The commenter then suggested that VA incorporate additional language from the 21st Century Cures Act (Pub. L. 114–255) into VA's definition of telehealth. The commenter quoted the following language from the Act (section 4012(c), 130 Stat 1033, 1187–8).

(c) Sense of Congress.—It is the sense of Congress that—. . . (2) any expansion of telehealth services under the Medicare program under title XVIII of such Act should—(A) recognize that telemedicine is the delivery of safe, effective, quality health care services, by a health care provider, using technology as the mode of care delivery; (B) meet or exceed the conditions of coverage and payment with respect to the Medicare program if the service was furnished in person, including standards of care, unless specifically addressed in subsequent legislation; and (C) involve clinically appropriate means to furnish such services.

VA has considered the language in the Act, but finds that it is beyond the scope of this rulemaking. We make no edits to the rule based on this comment.

We are making several minor revisions from the proposed rule. We said in the proposed rule that we would revise the undesignated center heading immediately after § 17.412 to read Authority of Health Care Providers to Practice in the Department. However, in order to maintain consistency in terminology we are amending the undesignated center heading by removing the term "Department" and adding in its place "VA." We are not making any edits to the meaning of the language in the proposed rule.

We said in the proposed rule that the title of new § 17.417 would be "Health care providers." However, because this rule addresses health care providers practicing telehealth, we are revising the title of § 17.417 to now read "Health care providers practicing via telehealth." We are similarly revising the title of paragraph (b) from "Health care provider's practice" to now read "Health care provider's practice via telehealth." We are not making any edits to the meaning of the language in the proposed rule.

We said in proposed paragraph (a)(2)(iii) that a health care provider was an individual who "Maintains credentials (*e.g.*, a license, registration, or certification) in accordance with the requirements of his or her medical specialty as identified under 38 U.S.C. 7402(b)." In order to maintain



consistency in terminology within this section, we are amending paragraph (a)(2)(iii) by removing the term “medical specialty” and adding in its place health care specialty. We are making a similar amendment to paragraph (c) by removing the term “medical and hospital care” and adding in its place “health care and hospital services.” We are not making any edits to the meaning of the language in the proposed rule.

Proposed paragraph (b)(1) said, in part, “telehealth services, within their scope of practice and in accordance with privileges granted to them by the Department . . .”. However, in order to maintain consistency in terminology within this section, we are amending paragraph (b)(1) by removing the term “Department” and adding in its place “VA.” We are also adding the term “functional statement” and replacing “and” with “and/or” when describing when health care providers can provide telehealth services. Health care providers practice in accordance with their functional statement or scope of practice (for those not granted privileges) or privileges granted to them by VA; as such, we consider these clarifying revisions. We are not making any edits to the meaning of the language in the proposed rule.

Based on the rationale set forth in the **SUPPLEMENTARY INFORMATION** to the proposed rule and in this final rule, VA is adopting the proposed rule with the edits discussed in this final rule.

#### **Executive Order 13132, Federalism**

Section 4 of Executive Order 13132 (Federalism) requires an agency that is publishing a regulation that preempts State law to follow certain procedures. Section 4(b) requires agencies to “construe any authorization in the statute for the issuance of regulations as authorizing preemption of State law by rulemaking only when the exercise of State authority directly conflicts with the exercise of Federal authority under the Federal statute or there is clear evidence to conclude that the Congress intended the agency to have the authority to preempt State law.” Section 4(c) states “Any regulatory preemption of State law shall be restricted to the minimum level necessary to achieve the objectives of the statute pursuant to which the regulations are promulgated.” Section 4(d) requires that when an agency “foresees the possibility of a conflict between State law and Federally protected interests within its area of regulatory responsibility, the agency shall consult, to the extent practicable, with appropriate State and local officials in an effort to avoid such a conflict.” Section 4(e) requires that

when an agency “proposes to act through adjudication or rulemaking to preempt State law, the agency shall provide all affected State and local officials notice and an opportunity for appropriate participation in the proceedings.” Section 6(c) states that “To the extent practicable and permitted by law, no agency shall promulgate any regulation that has federalism implications and that preempts State law, unless the agency, prior to the formal promulgation of the regulation, (1) consulted with State and local officials early in the process of developing the proposed regulation; (2) in a separately identified portion of the preamble to the regulation as it is to be issued in the **Federal Register**, provides to the Director of the Office of Management and Budget a federalism summary impact statement, which consists of a description of the extent of the agency’s prior consultation with State and local officials, a summary of the nature of their concerns and the agency’s position supporting the need to issue the regulation, and a statement of the extent to which the concerns of State and local officials have been met; and (3) makes available to the Director of the Office of Management and Budget any written communications submitted to the agency by State and local officials.”

Because this final rule preempts certain State laws, VA consulted with State officials in compliance with sections 4(d) and (e), as well as section 6(c) of Executive Order 13132. VA sent a letter to the National Governor’s Association, Association of State and Provincial Psychology, National Council of State Boards of Nursing, Federation of State Medical Boards, Association of Social Work Boards, and National Association of State Directors of Veterans Affairs on July 12, 2017, to notify them of VA’s intent to allow VA health care providers to practice telehealth irrespective of the location of the health care provider or beneficiary in any State and regardless of State telehealth restrictions. In addition, the Director of the Federation of State Medical Boards solicited comments and input from the nation’s State Medical Boards. The Wisconsin Medical Examining Board unanimously passed a motion in support of the rule. The Rhode Island Board of Medical Licensure & Discipline (BMLD) responded to our letter by saying that BMLD considers physicians employed by VA to be exempt from license requirements as long as such physician maintains a valid license in another U.S. jurisdiction. BMLD also indicated that

the exemption does not necessarily extend to prescribing controlled substances without an appropriate DEA registration. In response to that issue, we said in the proposed rule that, if finalized, VA health care providers would be subject to “the limitations imposed by the Controlled Substances Act, 21 U.S.C. 801, *et seq.*, on the authority to prescribe or administer controlled substances, as well as any other limitations on the provision of VA care set forth in applicable Federal law and policy.” The State of Utah Department of Commerce also said that the Utah Occupations and Professions Licensing Act exempts from licensure requirements in Utah physicians, physician assistants, advanced practice nurses, psychologists or other health care providers who provide telehealth services as part of their VA employment as long as such health care provider is licensed in any State. Utah supports VA’s efforts to enhance telehealth services to all veterans. The Florida Board of Medicine said that Florida does not prohibit the practice of telehealth except in certain circumstances and provided as an example that an in-person examination is required each time a physician issues a certification for medical marijuana. This final rule supersedes any State requirement regarding the practice of telehealth, such as the in-person examination requirement in Florida, and would maintain the restrictions imposed by Federal law and policy regarding the prescription of controlled substances. The North Carolina Medical Board recognizes the shortage of psychiatric care in rural and medically underserved communities and supports VA’s initiative.

The President of the National Association of State Directors of Veterans Affairs (NASDVA) sent an email to all of its State directors informing the directors of the association’s intent to fully support VA’s initiative. NASDVA also formally responded to our letter, and supports VA’s plans to amend its regulations and enhance access to health care via telehealth services. The National Council of State Boards of Nursing (NCSBN) supports VA’s initiative for health care providers to deliver services via telehealth, as long as such providers maintain a valid State license. However, the NCSBN does not support expanding VA State licensure exemptions to personal services contractors who practice telehealth. We said in the proposed rulemaking that VA contractors would not be permitted to practice telehealth services beyond what



is authorized by their State license, certification, or registration, and that has not changed in this final rule.

The Chief Executive Officer of the Association of State and Provincial Psychology Boards formally responded to our letter and indicated that this rule aligns with their current initiatives, specifically, Psychology Interjurisdictional Compact (PSYPACT) legislation, which has been adopted in three jurisdictions and is under active consideration in many more States. The PSYPACT legislation allows psychologists to provide telepsychology services across State lines via a compact without obtaining additional licenses. The Chief Executive Officer further said that these services will assist in addressing the delivery of telehealth services to veterans.

The Veterans' Rural Health Advisory Committee (VRHAC) formally submitted a letter in support of the proposed rule. The letter said that although VA leads the way in being the largest provider of telehealth in the country, there are barriers that affect many rural and highly rural areas, which includes limited internet or cellular access with sufficient bandwidth to support the required applications and also State legislations that restrict the practice of telehealth across State lines or into a veteran's home. The commenter supports the proposed rule and further adds that expanding telehealth to rural and highly rural veterans across State lines would strengthen the delivery of care to enrolled veterans who live in rural and highly rural areas and supports the critical need for access to mental health care.

The West Virginia Board of Osteopathic Medicine responded to VA's letter and indicated that West Virginia has made legislative changes to encourage physician participation in the VA system. The commenter said that W.Va. Code 30-14-12c authorizes the West Virginia licensing boards to issue a license to a physician licensed in another State via reciprocity when the applicant presents proof that they are a VA employee working in a VA medical facility that is located in a county where a nursing home is operated by the West Virginia Department of Veteran's Assistance. Also, W.Va. Code 30-14-12d states the requirements for practicing telemedicine in West Virginia and defines that the practice of medicine occurs where the patient is located and defines what constitutes a physician-patient relationship. The commenter said that the West Virginia Board of Osteopathic Medicine rarely knows when a VA physician is practicing in West Virginia without a

West Virginia State license. However, the commenter cautioned that if a VA physician is licensed in West Virginia and does not follow state law and such action becomes known to the Board, the Board would file a complaint and investigate such action. The commenter said that their telehealth law was written to protect patients and indicated that veterans deserved the same high quality care. As we stated in the proposed rule, we are preempting State law as it applies to health care providers who practice telehealth while acting within the scope of their VA employment, and that has not changed in this final rule.

The Pennsylvania State Board of Medicine responded to VA's letter and acknowledged the potential value for telehealth to expand access to health care, especially in rural and underserved areas. The commenter further stated that Pennsylvania law on the Interstate Medical Licensure Compact affirms that the practice of medicine occurs where the patient is located at the time of the health care encounter, which requires the physician to be under the jurisdiction of the State medical board where the patient is located. The commenter indicated that VA has oversight of its health care providers, however, the foundational principle that the physician should be licensed where the patient is located helps to assure the safety, quality, and accountability of the care provided. This rule preempts State law as it applies to health care providers who practice telehealth while acting within the scope of their VA employment.

The Michigan Department of Licensing and Regulatory Affairs responded to VA's letter by stating that Michigan law does not require a VA health care provider to hold a Michigan State license in the discharge of official duties in a VA facility. The commenter also stated that telehealth at a VA medical facility would be permitted. However, if the health care provider is delivering care to the beneficiary's home, such provider would need a Michigan State license. As we indicated in the proposed rule, VA preempts State law as it applies to health care providers who practice telehealth while acting within the scope of their VA employment, and that has not changed in this final rule.

The Virginia Board of Medicine responded to VA's letter by stating that the Executive Committee of the Board met and supported the enhancement of access to care for veterans. The commenter stated that the proposed rule should benefit many beneficiaries that have little or no access to health care.

The comments provided above were placed on *Regulations.gov* for public inspection during the comment period. Stakeholders also had an opportunity to provide comments during the notice and comment period.

This final rule complies with Executive Order 13132 by (1) identifying where the exercise of State authority would directly conflict with the rule; (2) limiting preemption to these areas of conflict; (3) restricting preemption to the minimum level necessary to achieve the objectives of the statutes pursuant to which the rule is promulgated; (4) consulting with the external stakeholders listed in this rule; and (5) providing opportunity for all affected State and local officials to comment on this final rulemaking.

#### **Effect of Rulemaking**

Title 38 of the Code of Federal Regulations, as revised by this final rule, represents VA's implementation of its legal authority on this subject. Other than future amendments to this rule or governing statutes, no contrary guidance or procedures are authorized. All existing or subsequent VA guidance must be read to conform with this rule if possible. If not possible, such guidance is superseded by this rule.

#### **Paperwork Reduction Act**

This final rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3521).

#### **Regulatory Flexibility Act**

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. This final rule directly affects only individuals who are VA employees and will not directly affect small entities. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604.

#### **Executive Orders 12866, 13563, and 13771**

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review)

emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a “significant regulatory action,” requiring review by the Office of Management and Budget (OMB), unless OMB waives such review, as “any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of \$100 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; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in this Executive Order.”

OMB has determined that this is a significant regulatory action under Executive Order 12866 because of the policy implications. This final rule is considered an E.O. 13771 deregulatory action. Details on the estimated cost savings of this final rule can be found in the rule’s economic analysis. VA’s impact analysis can be found as a supporting document at <http://www.regulations.gov>, usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its impact analysis are available on VA’s website at <http://www.va.gov/orpm/>, by following the link for “VA Regulations Published from FY 2004 Through Fiscal Year to Date.”

#### Unfunded Mandates

The Unfunded Mandates Reform Act of 1995, 2 U.S.C. 1532, requires that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100 million or more (adjusted annually for inflation) in any one year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

#### Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are: 64.007, Blind Rehabilitation Centers; 64.008, Veterans Domiciliary Care;

64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; 64.022, Veterans Home Based Primary Care; 64.039, CHAMPVA; 64.040, VHA Inpatient Medicine; 64.041, VHA Outpatient Specialty Care; 64.042, VHA Inpatient Surgery; 64.043, VHA Mental Health Residential; 64.044, VHA Home Care; 64.045, VHA Outpatient Ancillary Services; 64.046, VHA Inpatient Psychiatry; 64.047, VHA Primary Care; 64.048, VHA Mental Health Clinics; 64.049, VHA Community Living Center; and 64.050, VHA Diagnostic Care.

#### List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs—health, Grant programs—veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

#### Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Gina S. Farrisee, Deputy Chief of Staff, Department of Veterans Affairs, approved this document on February 6, 2018, for publication.

Dated: May 8, 2018.

#### Consuela Benjamin,

*Regulations Development Coordinator, Office of Regulation Policy & Management, Office of the Secretary, Department of Veterans Affairs.*

For the reasons set forth in the preamble, we are amending 38 CFR part 17 as follows:

#### PART 17—MEDICAL

■ 1. The authority citation for part 17 is amended by adding an entry for § 17.417 in numerical order to read in part as follows:

**Authority:** 38 U.S.C. 501, and as noted in specific sections.

\* \* \* \* \*

Section 17.417 also issued under 38 U.S.C. 1701 (note), 1709A, 1712A (note), 1722B, 7301, 7330A, 7401–7403, 7406 (note).

\* \* \* \* \*

■ 2. Revise the undesignated center heading immediately after § 17.412 to read as follows:

#### Authority of Health Care Providers to Practice in VA

■ 3. Add § 17.417 to read as follows:

#### § 17.417 Health care providers practicing via telehealth.

(a) *Definitions.* The following definitions apply to this section.

(1) *Beneficiary.* The term beneficiary means a veteran or any other individual receiving health care under title 38 of the United States Code.

(2) *Health care provider.* The term health care provider means an individual who:

(i) Is licensed, registered, or certified in a State to practice a health care specialty identified under 38 U.S.C. 7402(b);

(ii) Is appointed to an occupation in the Veterans Health Administration that is listed in or authorized under 38 U.S.C. 7401(1) or (3);

(iii) Maintains credentials (e.g., a license, registration, or certification) in accordance with the requirements of his or her health care specialty as identified under 38 U.S.C. 7402(b); and

(iv) Is not a VA-contracted health care provider.

(3) *State.* The term State means a State as defined in 38 U.S.C. 101(20), or a political subdivision of such a State.

(4) *Telehealth.* The term telehealth means the use of electronic information or telecommunications technologies to support clinical health care, patient and professional health-related education, public health, and health administration.

(b) *Health care provider’s practice via telehealth.* (1) Health care providers may provide telehealth services, within their scope of practice, functional statement, and/or in accordance with privileges granted to them by VA, irrespective of the State or location within a State where the health care provider or the beneficiary is physically located. Health care providers’ practice is subject to the limitations imposed by the Controlled Substances Act, 21 U.S.C. 801, *et seq.*, on the authority to prescribe or administer controlled substances, as well as any other limitations on the provision of VA care set forth in applicable Federal law and policy. This section only grants health care providers the ability to practice telehealth within the scope of their VA employment and does not otherwise

grant health care providers additional authorities that go beyond what is required or authorized by Federal law and regulations or as defined in the laws and practice acts of the health care providers' State license, registration, or certification.

(2) Situations where a health care provider's VA practice of telehealth may be inconsistent with a State law or State license, registration, or certification requirements related to telehealth include when:

(i) The beneficiary and the health care provider are physically located in different States during the episode of care;

(ii) The beneficiary is receiving services in a State other than the health care provider's State of licensure, registration, or certification;

(iii) The health care provider is delivering services in a State other than the health care provider's State of licensure, registration, or certification;

(iv) The health care provider is delivering services either on or outside VA property;

(v) The beneficiary is receiving services while she or he is located either on or outside VA property;

(vi) The beneficiary has or has not previously been assessed, in person, by the health care provider; or

(vii) Other State requirements would prevent or impede the practice of health care providers delivering telehealth to VA beneficiaries.

(c) *Preemption of State law.* To achieve important Federal interests, including, but not limited to, the ability to provide the same complete health care and hospital service to beneficiaries in all States under 38 U.S.C. 7301, this section preempts conflicting State laws relating to the practice of health care providers when such health care providers are practicing telehealth within the scope of their VA employment. Any State law, rule, regulation or requirement pursuant to such law, is without any force or effect on, and State governments have no legal authority to enforce them in relation to, this section or decisions made by VA under this section.

[FR Doc. 2018-10114 Filed 5-10-18; 8:45 am]

**BILLING CODE 8320-01-P**

## ENVIRONMENTAL PROTECTION AGENCY

### 40 CFR Part 52

[EPA-R04-OAR-2017-0550; FRL-9977-93—Region 4]

#### Air Plan Approval; KY; Fine Particulate Matter and Ozone NAAQS Revisions

**AGENCY:** Environmental Protection Agency.

**ACTION:** Final rule.

**SUMMARY:** The Environmental Protection Agency (EPA) is taking final action to approve portions of State Implementation Plan (SIP) revisions submitted by the Commonwealth of Kentucky, through the Kentucky Division for Air Quality, on December 21, 2016, and August 29, 2017, on behalf of the Louisville Metro Air Pollution Control District (District). The changes to the SIP that EPA is taking final action to approve are the portions of the submittals that modify the District's Ambient Air Quality Standards regulation, specifically changes to the District's air quality standards for fine particulate matter (PM<sub>2.5</sub>) and ozone to reflect the 2012 PM<sub>2.5</sub> and 2015 ozone national ambient air quality standards (NAAQS). EPA has determined that the December 21, 2016, and August 29, 2017, SIP revisions are consistent with the Clean Air Act (CAA or Act). EPA will act on the other portions of the December 21, 2016, and August 29, 2017, submittals in a separate action.

**DATES:** This rule will be effective June 11, 2018.

**ADDRESSES:** EPA has established a docket for this action under Docket Identification No. EPA-R04-OAR-2017-0550. All documents in the docket are listed on the [www.regulations.gov](http://www.regulations.gov) website. Although listed in the index, some information is not publicly available, *i.e.*, Confidential Business Information 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 either electronically through [www.regulations.gov](http://www.regulations.gov) or in hard copy at the Air Regulatory Management Section, Air Planning and Implementation Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street SW, Atlanta, Georgia 30303-8960. EPA requests that if at all possible, you contact the person 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 Federal holidays.

#### FOR FURTHER INFORMATION CONTACT:

Madolyn Sanchez, Air Regulatory Management Section, Air Planning and Implementation Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street SW, Atlanta, Georgia 30303-8960. Ms. Sanchez can be reached via telephone at (404) 562-9644 or via electronic mail at [sanchez.madolyn@epa.gov](mailto:sanchez.madolyn@epa.gov).

#### SUPPLEMENTARY INFORMATION:

##### I. Background

Sections 108 and 109 of the CAA govern the establishment, review, and revision, as appropriate, of the NAAQS to protect public health and welfare. The CAA requires periodic review of the air quality criteria—the science upon which the standards are based—and the standards themselves. EPA's regulatory provisions that govern the NAAQS are found at 40 CFR 50—*National Primary and Secondary Ambient Air Quality Standards*.

In a proposed rulemaking published on February 8, 2018 (83 FR 5593), EPA proposed to approve into the Kentucky SIP the portions of the revisions to the Jefferson County<sup>1</sup> air quality regulations addressing Regulation 3.01, *Ambient Air Quality Standards*, submitted by the Commonwealth on December 21, 2016, and August 29, 2017. Regulation 3.01 is amended<sup>2</sup> by updating air quality standards in Section 7 for PM<sub>2.5</sub> and ozone to reflect the most recent NAAQS, removing the numbering of the subsections in Section 7, and making textual modifications to the footnotes. The details of Kentucky's submissions and the rationale for EPA's action are explained in the proposed rulemaking. Comments on the proposed rulemaking were due on or before March 12, 2018.

<sup>1</sup> In 2003, the City of Louisville and Jefferson County governments merged and the "Jefferson County Air Pollution Control District" was renamed the "Louisville Metro Air Pollution Control District." However, each of the regulations in the Jefferson County portion of the Kentucky SIP still has the subheading "Air Pollution Control District of Jefferson County." Thus, to be consistent with the terminology used in the SIP, EPA refers throughout this notice to regulations contained in the Jefferson County portion of the Kentucky SIP as the "Jefferson County" regulations.

<sup>2</sup> The District refers to the revised version of Regulation 3.01 in its December 21, 2016, submittal as "Version 6" and the revised version of Regulation 3.01 in its August 29, 2017, submittal as "Version 7." Upon EPA's final approval of changes to Regulation 3.01, the text of the regulation in the SIP will reflect Version 7.