a. Title level metadata: serial or journal title, ISSN, publisher, frequency, place of publication.

b. Article level metadata, as relevant/or applicable: volume(s), number(s), issue dates(s), article title(s), article author(s), article identifier (DOI, etc.).

c. With other descriptive metadata (*e.g.,* subject heading(s), descriptor(s), abstract(s)), rather than without.

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i. BITS-compliant (NLM Book DTD).

ii. EPUB-compliant.

iii. Other widely-used book DTD/schemas (*e.g.,* TEI, DocBook, etc.).

b. Page-oriented rendition:

i. PDF/UA (Portable Document Format/Universal Accessibility; compliant with ISO 14289–1).

ii. PDF/A (Portable Document Format/Archival; compliant with ISO 19005).

ii. PDF (Portable Document Format; highest quality available, with features such as searchable text, embedded fonts, lossless compression, high resolution images, device-independent specification of colorspace; content tagging; includes document formats such as PDF/X).

c. Other structured markup formats:

i. XHTML or HTML, with DOCTYPE declaration and presentation stylesheet(s).

ii. XML-based document formats (widely-used and publicly-documented), with presentation style sheet(s) if applicable. Includes ODF (ISO/IEC 26300) and OOXML (ISO/IEC 29500).

iii. SGML, with included or accessible DTD.

iv. Other XML-based non-proprietary formats, with presentation stylesheet(s).

v. XML-based formats that use proprietary DTDs or schemas, with presentation stylesheet(s).

d. PDF (web-optimized with searchable text).

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ii. Plain text.

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iv. Other text formats not listed here.

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b. All updates, supplements, releases, and supersessions published as part of the work and offered for sale or distribution must be submitted and received in a regular and timely manner for proper maintenance of the deposit.

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Dated: October 5, 2020.

Maria Strong,

Acting Register of Copyrights and Director of the U.S. Copyright Office.

Approved by:

Carla D. Hayden,

Librarian of Congress.

[FR Doc. 2020–23101 Filed 11–10–20; 8:45 am]

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DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AQ94

Authority of VA Professionals To Practice Health Care

AGENCY: Department of Veterans Affairs.

ACTION: Interim final rule.

SUMMARY: The Department of Veterans Affairs (VA) is issuing this interim final rule to confirm that its health care professionals may practice their health care profession consistent with the scope and requirements of their VA employment, notwithstanding any State license, registration, certification, or other requirements that unduly interfere with their practice. Specifically, this rulemaking confirms VA's current practice of allowing VA health care professionals to deliver health care services in a State other than the health care professional's State of licensure, registration, certification, or other State requirement, thereby enhancing beneficiaries' access to critical VA health care services. This rulemaking also confirms VA's authority to establish national standards of practice for health care professionals which will standardize a health care professional's practice in all VA medical facilities.

DATES: *Effective Date:* This rule is effective on November 12, 2020.

Comments: Comments must be received on or before January 11, 2021.

ADDRESSES: Comments may be submitted through *www.Regulations.gov* or mailed to, Beth Taylor, 10A1, 810 Vermont Avenue NW, Washington, DC 20420. Comments should indicate that they are submitted in response to [''RIN 2900–AQ94—Authority of VA Professionals to Practice Health Care.''] Comments received will be available at *regulations.gov* for public viewing, inspection, or copies.

FOR FURTHER INFORMATION CONTACT: Beth Taylor, Chief Nursing Officer, Veterans Health Administration. 810 Vermont Avenue NW, Washington, DC 20420, (202) 461–7250. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: On January 30, 2020, the World Health Organization (WHO) declared the COVID–19 outbreak to be a Public Health Emergency of International Concern. On January 31, 2020, the Secretary of the Department of Health and Human Services declared a Public Health Emergency pursuant to 42 United States Code (U.S.C.) 247d, for the entire United States to aid in the nation's health care community response to the COVID–19 outbreak. On March 11, 2020, in light of new data and the rapid spread in Europe, WHO declared COVID–19 to be a pandemic. On March 13, 2020, the President declared a National Emergency due to COVID–19 under sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq.*) and consistent with section 1135 of the Social Security Act (SSA), as amended (42 U.S.C. 1320b–5). As a result of responding to the needs of our veteran population and other non-veteran beneficiaries during the COVID–19 National Emergency, where VA has had to shift health care

professionals to other locations or duties to assist in the care of those affected by this pandemic, VA has become acutely aware of the need to promulgate this rule to clarify the policies governing VA's provision of health care.

This rule is intended to confirm that VA health care professionals may practice their health care profession consistent with the scope and requirements of their VA employment, notwithstanding any State license, registration, certification, or other requirements that unduly interfere with their practice. In particular, it will confirm (1) VA's continuing practice of authorizing VA health care professionals to deliver health care services in a State other than the health care professional's State of licensure, registration, certification, or other requirement; and (2) VA's authority to establish national standards of practice for health care professions via policy, which will govern their employment, subject only to State laws where the health care professional is licensed, credentialed, registered, or subject to some other State requirements that do not unduly interfere with those duties.

We note that the term State as it applies to this rule means each of the several States, Territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico, or a political subdivision of such State. This definition is consistent with the term State as it is defined in 38 U.S.C. 101(20).

A conflicting State law is one that would unduly interfere with the fulfillment of a VA health care professional's Federal duties. We note that the policies and practices confirmed in this rule only apply to VA health care professionals appointed under 38 U.S.C. 7306, 7401, 7405, 7406, or 7408 or title 5 of the U.S. Code, which does not include contractors working in VA medical facilities or those working in the community.

VA has long understood its governing statutory authorities to permit VA to engage in these practices. Section 7301(b) of title 38 the U.S. Code establishes that the primary function of the Veterans Health Administration (VHA) within VA is to provide a complete medical and hospital service for the medical care and treatment of veterans. To allow VHA to carry out its medical care mission, Congress established a comprehensive personnel system for certain VA health care professionals, independent of the civil service rules. See Chapters 73–74 of title 38 of the U.S. Code. Congress granted the Secretary express statutory authority to establish the qualifications for VA's health care professionals, determine the hours and conditions of employment, take disciplinary action against employees, and otherwise regulate the professional activities of those individuals. 38 U.S.C. 7401–7464.

Section 7402 of 38 U.S.C. establishes the qualifications of appointees. To be eligible for appointment as a VA employee in a health care profession covered by section 7402(b) (other than a medical facility Director appointed under section 7402(b)(4)), most individuals, after appointment, must, among other requirements, be licensed, registered, or certified to practice their profession in a State, or satisfy some other State requirement. However, the standards prescribed in section 7402(b) establish only the basic qualifications for VA health care professionals and do not limit the Secretary from establishing other qualifications or rules for health care professionals.

In addition, the Secretary is responsible for the control, direction, and management of the Department, including agency personnel and management matters. See 38 U.S.C. 303.

Such authorities permit the Secretary to further regulate the health care professions to make certain that VA's health care system provides safe and effective health care by qualified health care professionals to ensure the well-being of those veterans who have borne the battle. In this rulemaking, VA is detailing its authority to manage its health care professionals by stating that they may practice their health care profession consistent with the scope and requirements of their VA employment, notwithstanding any State license, registration, certification, or other State requirements that unduly interfere with their practice. VA believes that this is necessary in order to provide additional protection for VA health care professionals against adverse State actions proposed or taken against them when they are practicing within the scope of their VA employment, particularly when they are practicing across State lines or when they are performing duties consistent with a VA national standard of practice for their health care profession.

Practice Across State Lines

Historically, VA has operated as a national health care system that authorizes VA health care professionals to practice in any State as long as they have a valid license, registration, certification, or fulfill other State requirements in at least one State. In doing so, VA health care professionals have been practicing within the scope of their VA employment regardless of any unduly burdensome State requirements that would restrict practice across State lines. We note, however, that VA may only hire health care professionals who are licensed, registered, certified, or satisfy some other requirement in a State, unless the statute requires or provides otherwise (*e.g.,* 38 U.S.C. 7402(b)(14)).

The COVID–19 pandemic has highlighted VA's acute need to exercise its statutory authority of allowing VA health care professionals to practice across State lines. In response to the pandemic, VA needed to and continues to need to move health care professionals quickly across the country to care for veterans and other beneficiaries and not have State licensure, registration, certification, or other State requirements hinder such actions. Put simply, it is crucial for VA to be able to determine the location and practice of its VA health care professionals to carry out its mission without any unduly burdensome restrictions imposed by State licensure, registration, certification, or other requirements. This rulemaking will support VA's authority to do so and will provide an increased level of protection against any adverse State action being proposed or taken against VA health care professionals who practice within the scope of their VA employment.

Since the start of the pandemic, in furtherance of VA's Fourth Mission, VA has rapidly utilized its resources to assist parts of the country that are undergoing serious and critical shortages of health care resources. VA's Fourth Mission is to improve the Nation's preparedness for response to war, terrorism, national emergencies, and natural disasters by developing plans and taking actions to ensure continued service to veterans, as well as to support national, State, and local emergency management, public health, safety and homeland security efforts.

VA has deployed personnel to support other VA medical facilities that have been impacted by COVID–19 as well as provided support to State and community nursing homes. As of July 2020, VA has deployed personnel to more than 45 States. VA utilized the Disaster Emergency Medical Personnel System (DEMPS), VA's main deployment program, for VA health care professionals to travel to locations deemed as national emergency or disaster areas, to help provide health care services in places such as New Orleans, Louisiana, and New York City, New York. As of June 2020, a total of 1,893 staff have been mobilized to meet the needs of our facilities and Fourth

Mission requests during the pandemic. VA deployed 877 staff to meet Federal Emergency Management Agency (FEMA) Mission requests, 420 health care professionals were deployed as DEMPS response, 414 employees were mobilized to cross level staffing needs within their Veterans Integrated Service Networks (VISN), 69 employees were mobilized to support needs in another VISN, and 113 Travel Nurse Corps staff responded specifically for COVID–19 staffing support. In light of the rapidly changing landscape of the pandemic, it is crucial for VA to be able to move its health care professionals quickly across the country to assist when a new hot spot emerges without fear of any adverse action from a State be proposed or taken against a VA health care professional.

We note that, in addition to providing in person health care across State lines during the pandemic, VA also provides telehealth across State lines. VA's video to home services have been heavily leveraged during the pandemic to deliver safe, quality VA health care while adhering to Centers for Disease Control and Prevention (CDC) physical distancing guidelines. Video visits to veterans' homes or other offsite location have increased from 41,425 in February 2020 to 657,423 in July of 2020. This represents a 1,478 percent utilization increase. VA has specific statutory authority under 38 U.S.C. 1730C to allow health care professionals to practice telehealth in any State regardless of where they are licensed, registered, certified, or satisfy some other State requirement. This rulemaking is consistent with Congressional intent under Public Law 115–185, sec. 151, June 6, 2018, codified at 38 U.S.C. 1730C for all VA health care professionals to practice across State lines regardless of the location of where they provide health care. This rulemaking will ensure that VA professionals are protected regardless of how they provide health care, whether it be via telehealth or in-person.

Beyond the current need to mobilize health care resources quickly to different parts of the country, this practice of allowing VA health care professionals to practice across State lines optimizes the VA health care workforce to meet the needs of all VA beneficiaries year-round. It is common practice within the VA health care system to have primary and specialty health care professionals routinely travel to smaller VA medical facilities or rural locations in nearby States to provide care that may be difficult to obtain or unavailable in that community. As of January 14, 2020, out of 182,100 licensed health care professionals who are employed by VA, 25,313 or 14 percent do not hold a State license, registration, or certification in the same State as their main VA medical facility. This number does not include the VA health care professionals who practice at a main VA medical facility in one State where they are licensed, registered, certified, or hold some other State requirement, but also practice at a nearby Community Based Outpatient Clinic (CBOC) in a neighboring State where they do not hold such credentials. Indeed, 49 out of the 140 VA medical facilities nationwide have one or more sites of care in a different State than the main VA medical facility.

Also, VA has rural mobile health units that provide health care services to veterans who have difficulty accessing VA health care facilities. These mobile units are a vital source of health care to veterans who live in rural and medically underserved communities. Some of the services provided by the mobile units include, but are not limited to, health care screening, mental health outreach, influenza and pneumonia vaccinations, and routine primary care. The rural mobile health units are an integral part of VA's goal of encouraging healthier communities and support VA's preventative health programs. Health care professionals who provide health care in these mobile units may provide services in various States where they may not hold a license, registration, or certification, or satisfy some other State requirement. It is critical that these health care professionals are protected from any adverse State action proposed or taken when performing these crucial services.

In addition, the practice of health care professionals of providing health care across State lines also gives VA the flexibility to hire qualified health care professionals from any State to meet the staffing needs of a VA health care facility where recruitment or retention is difficult. As of December 31, 2019, VA had approximately 13,000 vacancies for health care professions across the country. As a national health care system, it is imperative for VA to be able to recruit and retain health care professionals, where recruitment and retention is difficult, to ensure there is access to health care regardless of where the VA beneficiary resides. Permitting VA health care professionals to practice across State lines is an important incentive when trying to recruit for these vacancies, particularly during a pandemic, where private health care facilities have greater flexibility to offer more competitive pay and benefits. This is also especially beneficial in recruiting spouses of active service members who frequently move across the country.

National Standard of Practice

This rulemaking also confirms VA's authority to establish national standards of practice for health care professions. We note that this rulemaking does not create any such national standards; all national standards of practice will be created via policy. For the purposes of this rulemaking, a national standard of practice describes the tasks and duties that a VA health care professional practicing in the health care profession may perform and may be permitted to undertake. Having a national standard of practice means that individuals from the same VA health care profession may provide the same type of tasks and duties regardless of the VA medical facility where they are located or the State license, registration, certification, or other State requirement they hold. We emphasize that VA will determine, on an individual basis, that a health care professional has the necessary education, training, and skills to perform the tasks and duties detailed in the national standard of practice.

The need for national standards of practice have been highlighted by VA's large-scale initiative regarding the new electronic health record (EHR). VA's health care system is currently undergoing a transformational initiative to modernize the system by replacing its current EHR with a joint EHR with Department of Defense (DoD) to promote interoperability of medical data between VA and DoD. VA's new EHR system will provide VA and DoD health care professionals with quick and efficient access to the complete picture of a veteran's health information, improving VA's delivery of health care to our nation's veterans.

For this endeavor, DoD and VA established a joint governance over the EHR system. In order to be successful, VA must standardize clinical processes with DoD. This means that all health care professionals in DoD and VA who practice in a certain health care profession must be able to carry out the same duties and tasks irrespective of State requirements. The reason why this is important is because each health care profession is designated a role in the EHR system that sets forth specific privileges within the EHR that dictate allowed tasks for such profession. These tasks include, but are not limited to, dispensing and administrating medications; prescriptive practices; ordering of procedures and diagnostic imaging; and required level of oversight. VA has the ability to modify these privileges within EHR, however, VA

cannot do so on an individual user level, but rather at the role level for each health care profession. In other words, VA cannot modify the privileges for all health care professionals in one State to be consistent with that State's requirements; instead, the privileges can only be modified for every health care professional in that role across all States. Therefore, the privileges established within EHR cannot be made facility or State specific.

In order to achieve standardized clinical processes, VA and DoD must create the uniform standards of practice for each health care specialty. Currently, DoD has specific authority from Congress to create national standards of practice for their health care professionals under 10 U.S.C. 1094. While VA lacks a similarly specific statute, VA has the general statutory authority, as explained above, to regulate its health care professionals and authorize health care practices that preempt conflicting State law. This regulation will confirm VA's authority to do so. Absent such standardized practices, it will be incredibly difficult for VA to achieve its goal of being an active participant in EHR modernization because either some VA health care professionals would fear potential adverse State actions or DoD and VA would need to agree upon roles that are consistent with the most restrictive States' requirements to ensure that all health care professionals are acting within the scope of their State requirements. VA believes that agreement upon roles that are consistent with the most restrictive State is not an acceptable option because it will lead to delayed care and consequently decreased access and level of health care for VA beneficiaries.

One example that impacts multiple health care professions throughout the VA system is the ability to administer medication without a provider (physician or advanced practice nurse practitioner) co-signature. As it pertains to nursing, almost all States permit nurses to follow a protocol; however, some States, such as New York, North Carolina, and South Carolina, do not permit nurses to follow a protocol without a provider co-signature. A protocol is a standing order that has been approved by medical and clinical leadership if a certain sequence of health care events occur. For instance, if a patient is exhibiting certain signs of a heart attack, there is a protocol in place to administer potentially life-saving medication. If the nurse is the first person to see the signs, the nurse will follow the approved protocol and immediately administer the medication. However, if the nurse cannot follow the protocol and requires a provider co-signature, administration of the medication will be delayed until a provider is able to co-sign the order, which may lead to the deterioration of the patient's condition. This also increases the provider's workload and decreases the amount of time the provider can spend with patients.

Historically, VA physical therapists (PTs), occupational therapists, and speech therapists were routinely able to determine the need to administer topical medications during therapy sessions and were able to administer the topical without a provider co-signature. However, in order to accommodate the new EHR system and variance in State requirements, these therapists would need to place an order for all medications, including topicals, which would leave these therapists waiting for a provider co-signature in the middle of a therapy session, thus delaying care. Furthermore, these therapists also routinely ordered imaging to better assess the clinical needs of the patient, but would also have to wait for a provider co-signature, which will further delay care and increase provider workload.

In addition to requiring provider co-signatures, there will also be a significant decrease in access to care due to other variances in State requirements. For instance, direct access to PTs will be limited in order to ensure that the role is consistent with all State requirements. Direct access means that a beneficiary may request PT services without a provider's referral. However, while almost half of the States allow unrestricted direct access to PTs, over half of the States have some limitations on requesting PT services. For instance, in Alabama, a licensed PT may perform an initial evaluation and may only provide other services as delineated in specific subdivisions of the Alabama Physical Therapy Practice Act. Furthermore, in New York, PT treatment may be rendered by a licensed PT for 10 visits or 30 days, whichever shall occur first, without a referral from a physician, dentist, podiatrist, nurse practitioner, or licensed midwife. This is problematic as VA will not be able to allow for direct access due to these variances and direct access has been shown to be beneficial for patient care. Currently, VISN 23 is completing a two-year strategic initiative to implement direct access and have PTs embedded into patient aligned care teams (PACT). Outcomes thus far include decreased wait times, improved veteran satisfaction, improved provider satisfaction, and improved functional outcomes.

Therefore, VA will confirm its authority to ensure that health care professionals are protected against State action when they adhere to VA's national standards of practice. We reiterate that this rulemaking does not establish national standards of practice for each health care profession, but merely confirms VA's authority to do so, thereby preempting any State restrictions that unduly interfere with those practices. The actual national standards of practice will be developed in subregulatory policy for each health care profession. As such, VA will make a concerted effort to engage appropriate stakeholders when developing the national standards of practice.

Preemption

As previously explained, in this rulemaking, VA is confirming its authority to manage its health care professionals. Specifically, this rulemaking will confirm VA's long-standing practice of allowing its health care professionals to practice in a State where they do not hold a license, registration, certification, or satisfy some other State requirement. The rule will also confirm that VA health care professionals must adhere to VA's national standards of practice, as determined by VA policy, irrespective of conflicting State licensing, registration, certification, or other State requirements that unduly burden that practice. We do note that VA health care professionals will only be required to perform tasks and duties to the extent of their education, skill, and training. For instance, VA would not require a registered nurse to perform a task that the individual nurse was not trained to perform.

Currently, practice in accordance with VA employment, including practice across State lines or adhering to a VA standard of practice, may jeopardize VA health care professionals' credentials or result in fines and imprisonment for unauthorized health care practice. This is because most States have restrictions that limit health care professionals' practice or have rules that prohibit health care professionals from furnishing health care services within that State without a license, registration, certification, or other requirement from that State. We note that, some States, for example Rhode Island, Utah, and Michigan, have enacted legislation or regulations that specifically allow certain VA health care professionals to practice in those States when they do not hold a State license.

Several VA health care professionals have already had actions proposed or taken against them by various States

while practicing health care within the scope of their VA employment, while they either practiced in a State where they do not hold a license, registration, certification, or other State requirement that unduly interfered with their VA employment. In one instance, a VA psychologist was licensed in California but was employed and providing supervision of a trainee at the VA Medical Center (VAMC) in Nashville, Tennessee. California psychology licensing laws require supervisors to hold a license from the State where they are practicing and do not allow for California licensed psychologists to provide supervision to trainees or unlicensed psychologists outside the State of California. The California State Psychology Licensing Board proposed sanctions and fines of $1,000 for violating section 1387.4(a) of the CA Code of Regulations (CCR). The VA system did not qualify for the exemption of out of State supervision requirements listed in CCR section 1387.4. In addition, a VA physician who was licensed in Oregon, but was practicing at a VAMC in Biloxi, Mississippi had the status of their license changed from active to inactive because the Oregon Medical Board determined the professional did not reside in Oregon, in violation of Oregon's requirement that a physician physically reside in the State in order to maintain an active license.

This rulemaking serves to preempt State requirements, such as the ones discussed above, that were or can be used to take an action against VA health care professionals for practicing within the scope of their VA employment. State licensure, registration, certification, and other State requirements are preempted to the extent such State laws unduly interfere with the ability of VA health care professionals to practice health care while acting within the scope of their VA employment. As explained above, Congress provided general statutory provisions that permit the VA Secretary to authorize health care practices by health care professionals at VA, which serve to preempt conflicting State laws that unduly interfere with the exercise of health care by VA health care professionals pursuant to that authorization. Although some VA health care professionals are required by Federal statute to have a State license, *see, e.g.,* 38 U.S.C. 7402(b)(1)(C) (providing that, to be eligible to be appointed to a physician position at the VA, a physician must be licensed to practice medicine, surgery, or osteopathy in a State), a State may not attach a condition to the license that is unduly burdensome to or unduly interferes with the practice of health care within the scope of VA employment.

Under well-established interpretations of the Supremacy Clause, Federal laws and policies authorizing VA health care professionals to practice according to VA standards preempt conflicting State law: that is, a State law that prevents or unreasonably interferes with the performance of VA duties. *See, e.g., Hancock* v. *Train,* 426 U.S. 167, 178–81 (1976); *Sperry* v. *Florida,* 373 U.S. 379, 385 (1963); *Miller* v. *Arkansas,* 352 U.S. 187 (1956); *Ohio* v. *Thomas,* 173 U.S. 276, 282–84 (1899); *State Bar Disciplinary Rules as Applied to Federal Government Attorneys,* 9 Op. O.L.C. 71, 72–73 (1985). When a State law does not conflict with the performance of Federal duties in these ways, VA health care professionals are required to abide by the State law. Therefore, VA's policies and regulations will preempt State licensure, registration, and certification laws, rules, or other requirements only to the extent they conflict with the ability of VA health care professionals to practice health care while acting within the scope of their VA employment.

We emphasize that, in instances where there is no conflict with State requirements, VA health care professionals should abide by the State requirement. For example, if a State license requires a health care professional to have a certain number of hours of continuing professional education per year to maintain their license, the health care professional must adhere to this State requirement if it does not prevent or unduly interfere with the exercise of VA employment. To determine whether a State requirement is conflicting, VA would assess whether the State law unduly interferes on a case-by-case basis. For instance, if Oregon requires all licensed physicians to reside in Oregon, VA would likely find that it unduly interferes with already licensed VA physicians who reside and work for VA in the State of Mississippi. We emphasize that the intent of the regulation is to only preempt State requirements that are unduly burdensome and interfere with a VA health care professionals' practice for the VA. For instance, it would not require a State to issue a license to an individual who does not meet the education requirements to receive a license in that State. We note that this rulemaking also does not affect VA's existing requirement that all VA health care professionals adhere to restrictions imposed by the Controlled Substances Act, 21 U.S.C. 801 *et seq.* and implementing regulations at 21 CFR 1300, *et seq.,* to prescribe or administer controlled substances.

Any preemption of conflicting State requirements will be the minimum necessary for VA to effectively furnish health care services. It would be costly and time-consuming for VA to lobby each State board for each health care profession specialty to remove restrictions that impair VA's ability to furnish health care services to beneficiaries and then wait for the State to implement appropriate changes. Doing so would not guarantee a successful result.

Regulation

For these reasons, VA is establishing a new regulation titled Health care professionals' practice in VA, which will be located at 38 CFR 17.419. This rule will confirm the ability of VA health care professionals to practice their health care profession consistent with the scope and requirements of their VA employment, notwithstanding any State license, registration, certification, or other requirements that unduly interfere with their practice.

Subsection (a) of § 17.419 contains the definitions that will apply to the new section. Subsection (a)(1) contains the definition for beneficiary. We are defining the term beneficiary to mean a veteran or any other individual receiving health care under title 38 of the U.S. Code. We are using this definition because VA provides health care to veterans, certain family members of veterans, servicemembers, and others. This is VA's standard use of this term.

Subsection (a)(2) contains the definition for health care professional. We are defining the term health care professional to be an individual who meets specific criteria that is listed below.

Subsection (a)(2)(i) will require that a health care professional be appointed to an occupation in VHA that is listed or authorized under 38 U.S.C. 7306, 7401, 7405, 7406, or 7408 or title 5 of the U.S. Code.

Subsection (a)(2)(ii) requires that the individual is not a VA-contracted health care professional. A health care professional does not include a contractor or a community health care professional because they are not considered VA employees nor appointed under 38 U.S.C. 7306, 7401, 7405, 7406, or 7408 or title 5 of the U.S. Code.

Subsection (a)(2)(iii) lists the required qualifications for a health care professional. We note that these qualifications do not include all general

qualifications for appointment, such as to hold a degree of doctor of medicine; these qualifications are related to licensure, registration, certification, or other State requirements.

Subsection (a)(2)(iii)(A) states that the health care professional must have an active, current, full, and unrestricted license, registration, certification, or satisfies another State requirement in a State to practice the health care specialty identified under 38 U.S.C. 7402(b). This standard ensures that VA health care professionals are qualified to practice their individual health care specialty if the specialty requires such credential.

Subsection (a)(2)(iii)(B) states that the individual has other qualifications as prescribed by the Secretary for one of the health care professions listed under 38 U.S.C. 7402(b). Some health care professionals appointed under 38 U.S.C. 7401(3) whose qualifications are listed in 38 U.S.C. 7402(b) are not required to meet State license, registration, certification, or other requirements and rely on the qualifications prescribed by the Secretary. Therefore, these individuals would be included in this subsection and required to have the qualifications prescribed by the Secretary for their health care profession.

Subsection (a)(2)(iii)(C) states that the individual is otherwise authorized by the Secretary to provide health care services. This would include those individuals who practice a health care profession that does not require a State license, registration, certification, or other requirement and is also not listed in 38 U.S.C. 7402(b), but is authorized by the Secretary to provide health care services.

Subsection (a)(2)(iii)(D) includes individuals who are trainees or may have a time limited appointment to finish clinicals or other requirements prior to being fully licensed. Therefore, the regulation will state that the individual is under the clinical supervision of a health care professional that meets the requirements listed in subsection (a)(2)(iii)(A)–(C) and the individual must meet the requirements in subsection (a)(2)(iii)(D)(*i*) or (a)(2)(iii)(D)(*ii*).

Subsection (a)(2)(iii)(D)(*i*) states that the individual is a health professions trainee appointed under 38 U.S.C. 7405 or 7406 participating in clinical or research training under supervision to satisfy program or degree requirements.

Subsection (a)(2)(iii)(D)(*ii*) states that the individual is a health care employee, appointed under title 5 of the U.S. Code, 38 U.S.C. 7401(1) or (3), or 38 U.S.C. 7405 for any category of personnel described in 38 U.S.C. 7401(1) or (3) who must obtain an active, current, full and unrestricted licensure, registration, or certification or meet the qualification standards as defined by the Secretary within the specified time frame. These individuals have a time-limited appointment to obtain credentials. For example, marriage and family therapists require a certain number of supervised clinical post-graduate hours prior to receiving their license.

Lastly, as we previously discussed in this rulemaking, we are defining the term State in subsection (a)(3) as the term is defined in 38 U.S.C. 101(20), and also including political subdivisions of such States. This is consistent with the definition of State in 38 U.S.C. 1730C(f) which is VA's statutory authority to preempt State law when the covered health care professional is using telehealth to provide treatment to an individual under this title. We believe that it is important to define the term in the same way as it is defined for health care professionals practicing via telehealth so that way it is consistent regardless of whether the health care professional is practicing in-person or via telehealth. Moreover, as subdivisions of a State are granted legal authority from the State itself, it makes sense to subject entities created by a State, or authorized by a State to create themselves, to be subject to the same limitations and restrictions as the State itself.

Section 17.419(b) details that VA health care professionals must practice within the scope of their Federal employment irrespective of conflicting State requirements that would prevent or unduly interfere with the exercise of Federal duties. This provision confirms that VA health care professionals may furnish health care consistent with their VA employment obligations without fear of adverse action proposed or taken by any State. In order to clarify and make transparent how VA utilizes or intends to utilize our current statutory authority, we are providing a non-exhaustive list of examples.

The first example is listed in subsection (b)(1)(i). It states that a health care professional may practice their VA health care profession in any State irrespective of the State where they hold a valid license, registration, certification, or other qualification.

The second example is listed in subsection (b)(1)(ii). It states that a health care professional may practice their VA health care profession consistent with the VA national standard of practice as determined by VA. As previously explained, VA intends to establish national standards of practice via VA policy.

A health care professional's practice within VA will continue to be subject to the limitations imposed by the Controlled Substances Act, 21 U.S.C. 801, *et seq.* and implementing regulations at 21 CFR 1300, *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 will ensure that professionals are still in compliance with critical laws concerning the prescribing and administering of controlled substances. This requirement is stated in subsection (b)(2).

Subsection (c) expressly states the intended preemptive effect of § 17.419, to ensure that conflicting State and local laws, rules, regulations, and requirements related to health care professionals' practice will have no force or effect when such professionals are practicing health care while working within the scope of their VA employment. 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.

Executive Order 13132, Federalism

Executive Order 13132 establishes principles for preemption of State law when it is implicated in rulemaking or proposed legislation. Where a Federal statute does not expressly preempt State law, agencies shall 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 or there is clear evidence to conclude that the Congress intended the agency to have the authority to preempt State law.

In this situation, the Federal statutes do not expressly preempt State laws; however, VA construes the authorization established in 38 U.S.C. 303, 501, and 7401–7464 as authorizing preemption because the exercise of State authority directly conflicts with the exercise of Federal authority under these statutes. Congress granted the Secretary express statutory authority to establish the qualifications for VA's health care professionals, determine the hours and conditions of employment, take disciplinary action against employees, and otherwise regulate the professional activities of those individuals. 38 U.S.C. 7401–7464. Specifically, section 7402(b) states that most health care professionals, after appointment by VA, must, among other

requirements, be licensed, registered, or certified to practice their profession in a State. To that end, VA's regulations and policies will preempt any State law or action that conflicts with the exercise of Federal duties in providing health care at VA.

In addition, any regulatory preemption of State law must be restricted to the minimum level necessary to achieve the objectives of the statute pursuant to the regulations that are promulgated. In this rulemaking, State licensure, registration, and certification laws, rules, regulations, or other requirements are preempted only to the extent such State laws unduly interfere with the ability of VA health care professionals to practice health care while acting within the scope of their VA employment. Therefore, VA believes that the rulemaking is restricted to the minimum level necessary to achieve the objectives of the Federal statutes.

The Executive Order also requires an agency that is publishing a regulation that preempts State law to follow certain procedures. These procedures include: The agency consult with, to the extent practicable, the appropriate State and local officials in an effort to avoid conflicts between State law and Federally protected interests; and the agency provide all affected State and local officials notice and an opportunity for appropriate participation in the proceedings. For the reasons below, VA believes that it is not practicable to consult with the appropriate State and local officials prior to the publication of this rulemaking.

The National Emergency caused by COVID–19 has highlighted VA's acute need to quickly shift health care professionals across the country. As both private and VA medical facilities in different parts of the country reach or exceed capacity, VA must be able to mobilize its health care professionals across State lines to provide critical care for those in need. As explained in the Supplementary Information above, as of June 2020, a total of 1,893 staff have been mobilized to meet the needs of our facilities and Fourth Mission requests during the pandemic. VA deployed 877 staff to meet Federal Emergency Management Agency (FEMA) Mission requests, 420 health care professionals were deployed as DEMPS response, 414 employees were mobilized to cross level staffing needs within their Veterans Integrated Service Networks (VISN), 69 employees were mobilized to support needs in another VISN, and 113 Travel Nurse Corps staff responded specifically for COVID–19 staffing support. Given the speed in which it is required for our health care professionals to go to these facilities and provide health care, it is also essential that the health care professionals can follow the same standards of practice irrespective of the location of the facility or the requirements of their individual State license. This is important because if multiple health care professionals, such as multiple registered nurses, licensed in different States are all sent to one VA medical facility to assist when there is a shortage of professionals, it would be difficult and cumbersome if they could not all perform the same duties and each supervising provider had to be briefed on the tasks each registered nurse could perform. In addition, not having a uniform national scope of practice could limit the tasks that the registered nurses could provide. This rulemaking will provide health care professionals an increased level of protection against adverse State actions while VA strives to increase access to high quality health care across the VA health care system during this National Emergency. It would be time consuming and contrary to the public health and safety to delay implementing this rulemaking until we consulted with State and local officials. For these reasons, it would be impractical to consult with State and local officials prior to the publication of this rulemaking.

We note that this rulemaking does not establish any national standards of practice; instead, VA will establish the national standards of practice via subregulatory guidance. VA will, to the extent practicable, make all efforts to engage with State and local officials when establishing the national standards of practice via subregulatory guidance. Also, this interim final rule will have a 60-day comment period that will allow State and local officials the opportunity to provide their input on the rule.

Administrative Procedures Act

An Agency may forgo notice and comment required under the Administrative Procedures Act (APA), 5 U.S.C. 553, if the agency for good cause finds that compliance would be impracticable, unnecessary, or contrary to the public interest. An agency may also bypass the APA's 30-day publication requirement if good cause exists. The Secretary of Veterans Affairs finds that there is good cause under the provisions of 5 U.S.C. 553(b)(B) to publish this rule without prior opportunity for public comment because it would be impracticable and contrary to the public interest and finds that there is good cause under 5 U.S.C. 553(d)(3) to bypass its 30-day publication requirement for the same reasons as outlined above in the Federalism section, above.

In short, this rulemaking will provide health care professionals protection against adverse State actions while VA strives to increase access to high quality health care across the VA health care system during this National Emergency.

In addition to the needs discussed above regarding the National Emergency, it is also imperative that VA move its health care professionals across State lines in order to facilitate the implementation of the new EHR system immediately. VA implemented EHR at the first VA facility in October 2020 and additional sites are scheduled to have EHR implemented over the course of the next eight years. The next site is scheduled for implementation in Quarter 2 of Fiscal Year 2021 (*i.e.,* between January to March 2021). Due to the implementation of the new EHR system, VA expects decreased productivity and reduced clinical staffing during training and other events surrounding EHR enactment. VA expects a productivity decrease of up to 30 percent for the 60 days before implementation and the 120 days after at each site. Any decrease in productivity could result in decreased access to health care for our Nation's veterans.

In order to support this anticipated productivity decrease, VA is engaging in a ''national supplement,'' where health care professionals from other VA medical facilities will be deployed to those VA medical facilities and VISNs that are undergoing EHR implementation. The national supplement would mitigate reduced access during EHR deployment activities, such as staff training, cutover, and other EHR implementation activities. Over the eight-year deployment timeline, the national supplement is estimated to have full time employee equivalents of approximately 60 nurses, 3 pharmacy technicians, 5 mental health and primary care providers, and other VA health care professionals. We note that the actual number of VA health care professionals deployed to each site will vary based on need. The national supplement will require VA health care professionals on a national level to practice health care in States where they do not hold a State license, registration, certification, or other requirement. In addition, VISNs will be providing local cross-leveling and intra-VISN staff deployments to support EHRM implementation activities. Put simply, in order to mitigate the decreased

productivity as a result of EHR implementation, VA must transfer VA health care professionals across the country to States where they do not hold a license, registration, certification, or other requirement to assist in training on the new system as well as to support patient care.

Therefore, it would be impracticable and contrary to the public health and safety to delay implementing this rulemaking until a full public notice-and-comment process is completed. This rulemaking will be effective upon publication in the **Federal Register**. As noted above, this interim final rule will have a 60-day comment period that will allow State and local officials the opportunity to provide their input on the rule, and VA will take those comments into consideration when deciding whether any modifications to this rule are warranted.

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 Regulatory Flexibility Act, 5 U.S.C. 601–612, is not applicable to this rulemaking because a notice of proposed rulemaking is not required under 5 U.S.C. 553. 5 U.S.C. 601(2), 603(a), 604(a).

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. The Office of Information and Regulatory Affairs has determined that this rule is a significant regulatory action under Executive Order 12866.

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.''

This interim final rule is not subject to the requirements of E.O. 13771 because this rule results in no more than *de minimis* costs.

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 one year. This interim final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), the Office of Information and Regulatory Affairs designated this rule as not a major rule, as defined by 5 U.S.C. 804(2).

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. Brooks D. Tucker, Assistant Secretary for Congressional and Legislative Affairs, Performing the Delegable Duties of the Chief of Staff, Department of Veterans Affairs, approved this document on October 19, 2020, for publication.

Consuela Benjamin,

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

For the reasons stated in the preamble, the Department of Veterans Affairs is amending 38 CFR part 17 as set forth below:

PART 17—MEDICAL

■ 1. The authority citation for part 17 is amended by adding an entry for § 17.419 in numerical order to read in part as follows:

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

* * * * *

Section 17.419 also issued under 38 U.S.C. 1701 (note), 7301, 7306, 7330A, 7401–7403, 7405, 7406, 7408).

* * * * *

■ 2. Add § 17.419 to read as follows:

§ 17.419 Health care professionals' practice in VA.

(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 professional.* The term health care professional is an individual who:

(i) Is appointed to an occupation in the Veterans Health Administration that is listed in or authorized under 38 U.S.C. 7306, 7401, 7405, 7406, or 7408 or title 5 of the U.S. Code;

(ii) Is not a VA-contracted health care professional; and

(iii) Is qualified to provide health care as follows:

(A) Has an active, current, full, and unrestricted license, registration, certification, or satisfies another State requirement in a State;

(B) Has other qualifications as prescribed by the Secretary for one of

the health care professions listed under 38 U.S.C. 7402(b);

(C) Is an employee otherwise authorized by the Secretary to provide health care services; or

(D) Is under the clinical supervision of a health care professional that meets the requirements of subsection (a)(2)(iii)(A)–(C) of this section and is either:

(*i*) A health professions trainee appointed under 38 U.S.C. 7405 or 7406 participating in clinical or research training under supervision to satisfy program or degree requirements; or

(*ii*) A health care employee, appointed under title 5 of the U.S. Code, 38 U.S.C. 7401(1) or (3), or 38 U.S.C. 7405 for any category of personnel described in 38 U.S.C. 7401(1) or (3) who must obtain an active, current, full and unrestricted licensure, registration, certification, or meet the qualification standards as defined by the Secretary within the specified time frame.

(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.

(b) *Health care professional's practice.* (1) When a State law or license, registration, certification, or other requirement prevents or unduly interferes with a health care professional's practice within the scope of their VA employment, the health care professional is required to abide by their Federal duties, which includes, but is not limited to, the following situations:

(i) A health care professional may practice their VA health care profession in any State irrespective of the State where they hold a valid license, registration, certification, or other State qualification; or

(ii) A health care professional may practice their VA health care profession within the scope of the VA national standard of practice as determined by VA.

(2) VA health care professional's practice is subject to the limitations imposed by the Controlled Substances Act, 21 U.S.C. 801 *et seq.* and implementing regulations at 21 CFR 1300 *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.

(c) *Preemption of State law.* Pursuant to the Supremacy Clause, U.S. Const. art. IV, cl. 2, and in order 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 as required by 38 U.S.C. 7301, conflicting State laws, rules, regulations or requirements pursuant to such laws are without any force or effect, and State governments have no legal authority to enforce them in relation to actions by health care professionals within the scope of their VA employment.

[FR Doc. 2020–24817 Filed 11–10–20; 8:45 am]

BILLING CODE 8320–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R09–OAR–2020–0122; FRL–10014–19–Region 9]

Air Plan Approval; California; Butte County; El Dorado County; Mojave Desert Air Quality Management District; San Diego County; Ventura County

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: The Environmental Protection Agency (EPA) is taking final action to approve revisions to the Butte County Air Quality Management District (BCAQMD), El Dorado County Air Quality Management District (EDCAQMD), Mojave Desert Air Quality Management District (MDAQMD), San Diego County Air Pollution Control District (SDCAPCD) and Ventura County Air Pollution Control District (VCAPCD) portions of the California State Implementation Plan (SIP). These revisions concern rules that include definitions for certain terms that are necessary for the implementation of local rules that regulate sources of air pollution. We are approving the definitions rules under the Clean Air Act (CAA or the Act).

DATES: This rule will be effective on December 14, 2020.

ADDRESSES: The EPA has established a docket for this action under Docket ID No. EPA–R09–OAR–2020–0122. 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, *e.g.,* 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 through *https://www.regulations.gov,* or please contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section for additional availability information. If you need assistance in a language other than English or if you are a person with disabilities who needs a reasonable accommodation at no cost to you, please contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section.

FOR FURTHER INFORMATION CONTACT: Arnold Lazarus, EPA Region IX, 75 Hawthorne St., San Francisco, CA 94105. By phone: (415) 972–2304 or by email at *Lazarus.arnold@epa.gov*.

SUPPLEMENTARY INFORMATION: Throughout this document, ''we,'' ''us'' and ''our'' refer to the EPA.

Table of Contents

I. Proposed Action

On July 6, 2020 (85 FR 40156), the EPA proposed to approve the five amended rules listed in Table 1 as revisions to the California SIP. With respect to BCAQMD Rule 102, we determined that the State had not provided sufficient public process documentation to provide the basis for a rescission of the rule from the applicable SIP, but we recognized that, because the remaining definitions in BCAQMD Rule 102 had been moved to BCAQMD Rule 101 and because we are approving BCAQMD Rule 101, there is no reason to retain BCAQMD Rule 102 in the applicable SIP.

TABLE 1—SUBMITTED RULES

Local agency	Rule No.	Rule title	Rescinded	Amended/ revised	Submitted
BCAQMD	101	Definitions		12/14/2017	[1] 5/23/2018
BCAQMD	102	Definitions	[2] 12/14/2017		[3] 5/23/2018
EDCAQMD	101	General Provisions and Definitions		6/20/2017	8/9/2017
MDAQMD	102	Definition of Terms		1/28/2019	[4] 8/19/2019