The Proposed Amendment

Accordingly, pursuant to the authority delegated to me, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

■ 1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(f), 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

71.1 [Amended]

■ 2. The incorporation by reference in 14 CFR 71.1 of FAA Order JO 7400.11F, Airspace Designations and Reporting Points, dated August 10, 2021, and effective September 15, 2021, is amended as follows:

Paragraph 6005 Class E Airspace Areas Extending Upward From 700 Feet or More Above the Surface of the Earth.

* * * * *

AGL MI E5 Menominee, MI [Amended]

Menominee Regional Airport, MI
(Lat. 45°07′36″ N, long. 87°38′17″ W)

That airspace extending upward from 700 feet above the surface within a 6.7-mile radius of the Menominee Regional Airport.

Issued in Fort Worth, Texas, on August 17, 2022.

Martin A. Skinner,

Acting Manager, Operations Support Group, ATO Central Service Center.

[FR Doc. 2022–18016 Filed 8–22–22; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AQ59

Health Care Professionals Practicing Via Telehealth

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend its medical regulations that govern the VA health care professionals who practice health care via telehealth. This proposed rule would implement the authorities of the VA MISSION Act of 2018 and the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021.

DATES: Comments must be received on or before October 24, 2022.

ADDRESSES: Comments may be submitted through *www.Regulations.gov.* Comments should indicate that they are submitted in response to [''RIN 2900–AQ59—Health Care Professionals Practicing Via Telehealth.''] Comments received will be available at *regulations.gov* for public viewing, inspection or copies.

FOR FURTHER INFORMATION CONTACT: Kevin Galpin, MD, Executive Director Telehealth Services, Veterans Health Administration Office of Connected Care, 810 Vermont Avenue NW, Washington, DC 20420. (404) 771–8794. (This is not a toll-free number.) *Kevin.Galpin@va.gov.*

SUPPLEMENTARY INFORMATION: On June 6, 2018, section 151 of Public Law 115–182, the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, or the VA MISSION Act of 2018, amended title 38 of the United States Code (U.S.C.) by adding a new section 1730C, titled Licensure of health care professionals providing treatment via telemedicine. On June 11, 2018, a final rule VA published in May 2018, 83 FR 21897, titled Authority of Health Care Providers to Practice Telehealth (RIN 2900–AQ06), became effective; this regulation, which established 38 CFR 17.417, grants VA health care providers the ability to provide telehealth services within their scope of practice, functional statement, and/or in accordance with privileges granted to them by VA, in any location, within any State, irrespective of the State or location within a State where the health care provider or the beneficiary is physically located. Congress was aware VA was promulgating this regulation and sought to codify VA's telehealth authority through legislation. See H.R. Rep. No. 115–671, Part I, at 13–14. Congress passed the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (2021 NDAA), which further amended the definition of health care professional by including post graduate health care employees and health professions trainees. See Public Law 116–283, sec. 9101, January 2, 2021. Given the enactment of these laws, we are updating our regulations to implement the new statutory authority.

Section 1730C provides a definition of covered health care professionals that differs from the definition of health care provider under § 17.417(a). We propose this regulation to make these definitions consistent. Section 1730C(b)(1)(A) defines a covered health care professional to include those VA employees appointed under 38 U.S.C. 7306, 7401, 7405, 7406, 7408 and title 5 of the U.S. Code. Section 17.417(a) defined a health care provider as an individual who 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). To maintain consistency between 38 U.S.C. 1730C and § 17.417, VA is proposing to amend the definition of health care provider to instead refer to health care professionals. We would also renumber the definition in § 17.417 for clarity. VA proposes to add in § 17.417(a)(2)(i) that a health care professional would include those individuals who are appointed under 38 U.S.C. 7306, 7401, 7405, 7406, 7408, and title 5 of the U.S. Code.

VA is further proposing to amend the definition of health care professional to be consistent with section 1730C(b)(1)(C) in proposed § 17.417(a)(2)(ii) to state that VA health care professionals would be required to adhere to all standards for quality relating to the provision of health care in accordance with applicable VA policies. We note that while the statute uses the phrase provision of medicine, we propose to use the phrase provision of health care because we understand these terms to be equivalent and because the term health care is used more frequently in VA's regulations than medicine.

Consistent with current § 17.417, we would state in proposed § 17.417(a)(2)(iii) that VA-contracted health care professionals remain excluded from the definition of health care professional. We maintain this exclusion because contracted health care professionals and community care professionals are not appointed under 38 U.S.C. 7306, 7401, 7405, 7406, 7408, or title 5, U.S. Code.

We would also state in proposed § 17.417(a)(2)(iv)(A) that the health care professional is qualified to provide health care based on having an active, current, full, and unrestricted license, registration, certification, or satisfy another State requirement in a State to practice the health care profession of the health care professional. This language is similar to the language in section 1730C(b)(1)(D)(i).

Proposed § 17.417(a)(2)(iv)(B) would include those health care professions listed under 38 U.S.C. 7402(b)(14) that, although they may not be required to be licensed, registered or certified in their health care profession, may be required to satisfy another State requirement in a State that might limit them to practice telehealth. This additional provision

would recognize such qualifications as prescribed by the Secretary for those health care professions listed under 38 U.S.C. 7402(b)(14). This amendment is consistent with section 1730C(b)(1)(D)(2). Additionally, the proposed updates to the regulation are permitted pursuant to three general statutory provisions that permit VA to authorize health care practices by health care professionals at VA: 38 U.S.C. 303, 38 U.S.C. 7401, and 38 U.S.C. 7403(a)(1).

Proposed § 17.417(a)(2)(iv)(C) would be consistent with section 1730C(b)(1)(B) and state that a health care professional is an employee otherwise authorized by the Secretary to provide health care services.

The statutory authorities under 38 U.S.C. 303, 7401, and 7403(a)(1) also permit the VA Secretary to authorize VA health care professionals, including health professions trainees, other health care professionals, and those listed in the proposed regulation, to engage in telehealth. In addition, the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 amended section 1730C to expressly identify such persons within its statutory authority. We note that section 1730C uses the term postgraduate health care employee. However, we would instead use the term health care professional to maintain consistency in terminology with other regulations. See § 17.419. We would, therefore, state in proposed § 17.417(a)(2)(iv)(D) that a health care professional would also include those individuals who are under the clinical supervision of a health care professional that meets the requirements of paragraphs (a)(2)(iv)(A) through (C) of this section and is either a health professions trainee or a health care employee.

Health professions trainees work in an apprenticeship model with VA-employed health care professionals as part of their training programs and are not required to have a license, registration, certification, or other State requirement. Health professions trainees are appointed under 38 U.S.C. 7405 or 7406. Section 1730C(b)(3) authorizes trainees to provide health care via telehealth and as such, we would state in § 17.417(a)(2)(iv)(D)(*1*) that such trainee must be a health professions trainee appointed under 38 U.S.C 7405 or 38 U.S.C 7406 participating in clinical or research training under supervision to satisfy program or degree requirements.

Similarly, section 1730C(b)(2) includes health care employees who are appointed under title 5, U.S. Code, 38 U.S.C. 7401(1), (3), or 38 U.S.C. 7405 for any category of personnel described in 38 U.S.C. 7401(1) or (3). Health care employees must obtain full and unrestricted licensure, registration, or certification or meet the qualification standards as defined by the Secretary within the specified time frame. We would state these requirements in § 17.417(a)(2)(iv)(D)(*2*).

We propose to amend § 17.417(b)(1) for clarity. We would clarify the first part of the first sentence of § 17.417(b)(1), which would now be numbered as § 17.417(b)(1), by stating that when a State law, license, registration, certification, or other State requirement is inconsistent with this section, the health care professional is required to abide by their Federal duties and requirements. We would make this clarification because without a broad, clear statement about which standards a health care professional should follow when State requirements are inconsistent with VA requirements for a health care professional's practice via telehealth, such State requirements would create ambiguity for VA health care professionals, thereby delaying telehealth service delivery, and preventing VA from training and overseeing VA health care professionals based on a single, consistent standard. This change would also be consistent with the statute governing licensure requirements of VA health care professionals' practice via telehealth. See 38 U.S.C. 1730C(d)(1). One example is if VA requires verbal consent for telehealth but a State required written consent, the VA health care professional would only be required to obtain verbal consent. Alternatively, if State law did not require obtaining consent at all, but VA policy required verbal consent, the VA health care professional would still be required to obtain verbal consent. Another example is when a State has a specific training requirement for a health care professional for telehealth. We note that VA has specific training requirements for health care professionals who practice via telehealth that do not include each State's specific training or telehealth requirements. The VA health care professional must comply with VA's training requirement in order to practice via VA's telehealth program. In all instances, VA policy would establish requirements for quality and processes that would be met in all cases, but VA health care professionals would not be required to take additional steps or actions beyond those established in VA policy to comply with State law requirements.

We propose to add a new § 17.417(b)(2), which would restate the second part of the first sentence of current § 17.417(b)(1). However, we would clearly state that in order for the health care professional to be covered under this section, such professional must be practicing within the scope of their Federal duties. The provision of telehealth outside of the scope of the health care professional's Federal duties would not be covered by this rulemaking. We would, therefore, state in proposed § 17.417(b)(2) that VA health care professionals may practice their health care profession within the scope of their Federal duties in any State irrespective of the State or location within a State where the health care professional or the beneficiary is physically located, if the health care professional is using telehealth to provide health care to a beneficiary.

We propose to add a new § 17.417(b)(3) to restate the second sentence of current § 17.417(b)(1), but would add that the practice is limited by the Controlled Substances Act and its implementing regulations. Proposed § 17.417(b)(3) would state that health care professionals' 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 part 1300 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, regulation, and policy.

Section 1730C provides VA's authority to establish the scope of practice for health care professionals who practice telehealth. Section 1730C(d)(1) provides that federal law shall supersede any provisions of the law of any State to the extent that such provisions of State law are inconsistent with it. States are, therefore, prevented from interfering with the exercise of VA duties by imposing requirements that are inconsistent with federal duties and requirements of health care professionals who practice within the scope of their VA employment. While there is a general requirement that a Federal employee be licensed, registered, or certified by a State, a line must be drawn between reasonable and established rules of practice, which are understood to be incorporated by reference by Federal statutes requiring Federal employees to carry licenses, and rules that would penalize or otherwise interfere with the performance of authorized federal duties. *See* State Bar Disciplinary Rules as Applied to Federal Government Attorneys, 9 Op. O.L.C. 71, 72–73 (1985) (quotations omitted). A State's licensure laws or rules that would prevent a VA health care

professional from engaging in telehealth would fall into the latter category and therefore could be preempted. Given our statutory authority under section 1730C, which supersedes any provisions of State law to the extent that such provision of State law are inconsistent with a VA health care professional's practice via telehealth, we propose to remove the last part of the last sentence in § 17.417(b)(1).

We propose to add a new § 17.417(b)(4), which would restate § 17.417(b)(2) with changes described herein. We are clarifying current § 17.417(b)(4)(iii) and (iv). The current language is not clear as to where the health care professional or the beneficiary is located. Proposed paragraph § 17.417(b)(4) (iii) would now state the health care professional is delivering services while the professional is located in a State other than the health care professional's State of licensure, registration, or certification. Proposed § 17.417(b)(4)(iv) would now state the health care professional is delivering services while the professional is either on or outside VA property.

We propose to clarify current § 17.417(b)(2)(v) to be inclusive of all beneficiaries. We note that all beneficiaries do not identify as she or he. We would, therefore, amend § 17.417(b)(2)(v) to state the beneficiary is receiving services while the beneficiary is located either on or outside VA property.

Current § 17.417(b)(2)(vi) states that situations where a health care provider's VA practice of telehealth may be inconsistent with a State law, or State license, registration, or certification, or other requirement include when the beneficiary has or has not previously been assessed, in person, by the health care provider. We propose to eliminate the term ''has'' as it refers to having been previously assessed in person. Some States require that a patient be first assessed in person prior to being provided health care via telehealth. Therefore, this part of the provision would not be inconsistent with some State requirements. Proposed § 17.417(b)(4)(vi) would only provide for situations that would be inconsistent with State law or State license, registration, certification, or other requirements related to telehealth, which includes when the beneficiary has not been previously assessed, in person, by the health care professional. The proposed change would also be consistent with section 1730C(d)(1).

We propose to add a new § 17.417(b)(4)(vii), which would provide another example of a situation where a State license, registration, certification, or other State requirement may be inconsistent or conflict with VA policy. One example would be where a beneficiary has not provided VA with a signed written consent in order to receive health care via telehealth. This example is added because some States do not allow a health care professional to provide telehealth services to a beneficiary unless the beneficiary has signed a written consent form. VA regulations only require verbal consent for the provision of telehealth. Requiring signature consent would disadvantage beneficiaries who do not possess the technology or digital skills to complete a remote signature consent prior to their telehealth visits. This provision would allow for the provision of health care services via telehealth. VA is already bound to informed consent requirements under 38 U.S.C. 7331 as implemented by 38 CFR 17.32. Section 17.32 of 38 CFR mandates that all patient care furnished under title 38, including health care services via telehealth, shall be carried out with the full and informed consent of the patient or, in appropriate cases, a representative thereof. That consent is not required to be in writing except in the narrow circumstances set forth in 38 CFR 17.32(d)(1). Thus, because 38 U.S.C. 7331 requires, in relevant part, that the Secretary of Veterans Affairs, prescribe regulations to ensure, to the maximum extent practicable, that all VA patient care be carried out only with the full and informed consent of the patient, or in appropriate cases, a representative thereof, and VA has implemented 38 CFR 17.32 establishing the standards for obtaining informed consent from a patient for a medical treatment or a diagnostic or therapeutic procedure, we assert that 38 CFR 17.32, combined with 38 U.S.C. 7331 categorically excludes any State regulation of how VA health care professionals go about obtaining informed consent.

We would not restate current § 17.417(b)(2)(vii) because this information is already captured in proposed § 17.417(b)(1).

Finally, we propose to revise the list of authorities cited for § 17.417 to include section 1730C. We note that all prior authorities cited by this regulation would continue to apply and could protect VA health care professionals practicing telehealth in situations not covered by section 1730C. For example, section 1730C only protects VA health care professionals providing treatment to individuals under chapter 17 of title 38, U.S.C. VA provides treatment to servicemembers and other beneficiaries of the Department of Defense who are not eligible for VA health care under chapter 17 pursuant to sharing agreements entered into under section 8111 in chapter 81 of title 38, U.S.C. VA's general authority on which its original regulations were premised, 38 U.S.C. 303, 7401, and 7403(a)(1), would continue to cover VA health care professionals furnishing health care not otherwise covered by section 1730C. We propose to also include 38 U.S.C. 7306, 7405, 7406, and 7408. These new authorities cover individuals who would now be included as health care professionals under the proposed definition in § 17.417(a)(2). In addition, we would also include 38 U.S.C. 7331, which would cover the informed consent as previously stated in this rulemaking. The statutory authority for § 17.417 would now be 38 U.S.C. 1701 (note), 1709A, 1712A (note), 1722B, 1730C, 7301, 7306, 7330A, 7331, 7401–7403, 7405, 7406, 7408.

Executive Order 13132, Federalism

Executive Order 13132 provides the requirements for preemption of State law when it is implicated in rulemaking. 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. Through this rulemaking process, we can preempt any State law or action that conflicts with the exercise of Federal duties in providing health care via telehealth to VA beneficiaries.

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 State requirements are preempted only to the extent such State laws are inconsistent with the VA health care professionals' practicing health care via telehealth while acting within the scope of their VA employment. VA also has statutory authority under 38 U.S.C. 1730C to preempt State law. Therefore, we believe that the rulemaking is restricted to the minimum level necessary to achieve the objectives of the Federal statute.

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.

Because this proposed rule would preempt 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. On August 21, 2019, VA sent a letter to the following: National Association of Boards of Pharmacy (NABP), Association of State and Provincial Psychology Boards, National Governors Association, American Academy of Physicians Assistants (AAPA), National Council of State Boards of Nursing (NCSBN), National Association of State Directors of Veterans Affairs, Association of Social Work Boards (ASWB), and the Federation of State Medical Boards to state VA's intent to amend the current regulations that allow VA health care professionals to practice telehealth.

We received 11 comments from the State officials. We received three comments fully supporting the rule. The AAPA supported the objective of the proposed amendment to ensure qualified health care professionals, including trainees, employed by VA, provide veterans with the same high level of care and access to care no matter where a beneficiary or health care provider is located at the time health care is provided. AAPA also appreciated VA proposing to modify the telehealth regulation to add clarity so that, in situations where VA rules governing the practice of telehealth are in conflict with State laws or State license, registration, or certification requirements, the health care professional practicing telehealth at VA is required to adhere to VA policy or standards and is not at risk of losing their State license. AAPA stated that it supports the efforts VA is undertaking to improve the delivery of care for our nation's veterans and stands ready to assist VA in meeting its challenge to provide veterans with timely access to high quality medical care.

NABP supported expanding health care delivery by means of telehealth, specifically telepharmacy, and recognizes that telehealth can provide patients with quality health care that they may not otherwise receive or have difficulty accessing. The Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy (Model Act) provides model regulatory language for NABP's member boards. Pursuant to the recommendation of NABP's Task Force on the Regulation of Telepharmacy Practice, the Model Act was amended to include the practice of telepharmacy. The State boards of pharmacy also recognize the important benefits of telehealth services to the public. According to information provided to NABP from the State boards of pharmacy, approximately 40 States allow the practice of telepharmacy in some manner. NABP stated that it would communicate VA's intention to expand health care to veterans through telemedicine, encourage the State boards of pharmacy to review existing pharmacy laws and rules for hinderances to implementation of telemedicine services to veterans, and encourage the boards to make amendments to State laws and rules to facilitate telehealth access to veterans. NABP stated that the practice of telehealth, specifically telemedicine, between a health care provider and a veteran receiving care through the Veterans Health Administration is not typically subject to State regulatory oversight. One scenario that NABP wished to highlight is the legitimacy of controlled substance (CS) prescriptions that are issued by means of telecommunications that do not involve an initial face-to-face encounter for an exam/assessment, but are otherwise valid prescriptions under the Controlled Substances Act. If a CS prescription is issued via telemedicine without a face-to-face encounter and a veteran seeks the services of a community pharmacy to meet his or her immediate need, the community pharmacists may not be authorized to dispense the CS according to certain State pharmacy laws. Therefore, NABP stated it would communicate to the State boards of pharmacy about VA's telehealth initiative to help bridge the gap between the need for health care and veterans' access to it.

We received a comment from the Association of State and Provincial Psychology Boards (ASPPB). Based on a review of the information shared within the recent VA correspondences to ASPPB and ASPPB's knowledge of the strong training programs that occur throughout the nation under the authority of the VA, the ASPPB stated that they have no comments to refute the proposed upcoming changes to VA regulatory language on VA's proposed plans to amend its regulations to remove barriers and accelerate access to telehealth for veterans.

The other comments received were mostly in favor of the rule, however, the commenters expressed concern surrounding the addition of trainees as health care professionals who would be allowed to practice telehealth within the scope of their VA duties. The comments are as follows:

The ASWB requested a clarification of the definition of trainee. The ASWB asked if the term trainee included social work students in field placement only or if trainees included master of social work graduates under clinical supervision working towards licensure. The ASWB added that in both of these scenarios, the trainees would be bound to adhere to VA policies and procedures in addition to school policies as students and State policies while working towards their State licensure. The ASWB also stated that it requires a licensed social worker to obtain a State license in the State where the client is located as well as the State where the health care provider is located. The ASWB understands that VA has secure, advanced, and supervised telehealth infrastructure in place that protects the health care professional and client and is able to provide support services while the health care professional is practicing in a VA medical facility. However, the ASWB believes that this may not be the case in circumstances where the health care professional is practicing telehealth outside a VA medical facility. Social work regulators believe that by requiring a social worker to obtain a license in each jurisdiction where practice occurs, the client is better protected. The ASWB emphasized that jurisdictional boards have the power to investigate any complaints made against licensed social workers employed in VA and that VA's full cooperation with the investigation and enforcement related to licenses is needed for true protection of the public.

In response to ASWB's concerns, we note that VA has the statutory authority under 38 U.S.C. 1730C(d)(1) to preempt any provisions of the law of any State to the extent that such provisions of State law are inconsistent with this section. In addition, VA has already established in 38 CFR 17.417 that 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. As such, VA has the authority to allow social workers to practice health care via telehealth. Also, the qualifications of a VA social worker are stated in 38 U.S.C. 7402(b)(9), which include that the social worker must hold a master's degree in social work from a college or university approved by the

Secretary and be licensed or certified to independently practice social work in a State. With regards to social worker trainees, VA never intended that these trainees work without the supervision of an otherwise licensed social worker. The trainees will be supervised while practicing health care via telehealth. We appreciate the commenter's recognition of the quality of the VA telehealth program and that VA maintains a secure, advanced, and supervised telehealth infrastructure irrespective of the veterans or health care professional's location when delivering VA.

The NCSBN expressed concern regarding the expansion of telehealth privileges to nurse assistants and other assistive personnel as outlined in 38 U.S.C. 7401. Nurse assistants and other assistive personnel do not have a national governing body, leaving the regulation of these occupations to the individual States. The majority of States do not license the occupation and have widely inconsistent standards for certification. There is no national database for agencies to report disciplinary actions for many assistive personnel roles, creating a public protection issue for these for patients receiving care across State lines. NCBSN provided the following example: if VA fired a nurse assistant following an interstate telehealth interaction, there is no infrastructure by which those States can communicate nationally to ensure that appropriate disciplinary action is taken against the provider's licensure/certification across the country. Therefore, it would be possible that the provider could continue to practice in a different system and State without suffering any consequences. Additionally, NCSBN did not support allowing unlicensed or pre-licensure nurses to provide telehealth services as would be allowable for temporary full-time appointments under 38 U.S.C 7405. Boards of Nursing (BONs) do not have authority to discipline pre-licensure nurses, as they do not have an active license. Furthermore, BONs are unable to determine a nurse's competency without the completion and passage of the National Council Licensure Examination. Without a license, a nurse cannot be held accountable for a mistake by a BON, because there is no means to report them to a BON if an adverse event takes place. This also means there is no recourse for the patient if they are harmed. By allowing pre-licensure nurses to deliver telehealth services, VA would be exposing patients and nurses in the process of seeking licensure to great risk. Further, NCSBN stated that section 1730C(b)(1) defines a covered health professional as not only an employee of the Department appointed under the authority under section 7306, 7405, 7406, or 7408 of this title or title 5, but also a health care professional who has ''an active, current, full and unrestricted license, registration and certification in a State to practice the health care profession of the health care professional.'' NCSBN stated that while 38 U.S.C. 7405 includes unlicensed or pre-licensure individuals, it believed section 1730C explicitly states that in order to practice telemedicine, a provider must have an active license. NCSBN stated its firm belief that nurses should be fully licensed before practicing to ensure that they provide safe, competent care and retain the public protection mechanisms that allows VA to report disciplinary actions to the appropriate State licensing boards.

VA recognizes that 38 U.S.C. 1730C(b)(1)(D)(i) states that a covered health care professional must have an active, current, full, and unrestricted license, registration, or certification in a State to practice the health care profession of the health care professional. However, 38 U.S.C. 1730C was updated by the 2021 NDAA and section 1730C(b)(2) and (b)(3) now includes those individuals who are trainees and post graduate employees appointed under 38 U.S.C. 7405 and 7406. In addition, VA requires supervision of trainees pre-licensed nurses by a qualified health care professional who meet the requirement of stated in section 1730C(b)(1). VA also continuously monitors all health care professionals, including trainees, and has procedures in place to report any adverse action to the appropriate State licensing board.

VA received several comments regarding trainees. The commenters from the Virginia Board of Medicine, Federation of State Medical Boards, Kansas State Board of Healing Arts, and the Wisconsin Medical Examining Board stated that to ensure consistency in the quality of care between veterans and the general public, trainees should not be allowed to practice telehealth without supervision and that only such trainees that possessed full and unrestricted licenses should practice health care via telehealth. The commenters added that the care that is provided by VA must be of the highest quality, meaning from physicians who have been trained to practice independently, have proven their knowledge, clinical acumen, and skills, or, if not, are under the supervision of another physician who has. A commenter added that the proposed rule to amend the definition of health care provider to include trainees and authorize trainees to provide health care or telemedicine would mean that a trainee could practice independently via telemedicine or independently provide other health care without supervision, in violation of their license and with the risks of providing less than optimal care and potentially putting patients' lives at risk. They further stated that the proposed rule fails to recognize not only that States differ in qualifications to get a training license but also that these trainees differ in their knowledge and capabilities. In addition, a commenter argued that assigning a person with a trainee license to provide telemedicine or other health care is contrary to the VA mission and core value of excellence. Finally, they concluded that expanding the definition of health care provider to include trainees and asserting that where State law is inconsistent with VA practice the VA standards will prevail or supersede State law will promote lower standards of care for veterans.

In response to the comments about trainees and postgraduate employees practicing independently through telehealth, this rulemaking would not allow these individuals to practice without clinical supervision. In fact, this rulemaking explicitly requires that trainees and postgraduate employees only participate in telehealth under clinical supervision by an employee who is licensed, registered, or certified by a State, or under clinical supervision by an employee who otherwise meets qualifications as defined by the Secretary.

To be covered by the authorization to practice telehealth in 38 U.S.C. 1730C(b), a VA health care professional must have an active, current, full, and unrestricted license, registration, or certification in a State to practice the health care profession of the health care professional or, with respect to a health care profession listed under section 7402(b) of Title 38, have qualifications for such profession as set forth by the secretary. Trainees and postgraduate employees are expressly authorized to participate in telehealth in the 2021 NDAA updates to 38 U.S.C. 1730C, but only under the supervision of one of these health care professionals.

Additionally, the VA Secretary has statutory authority independent of 38 U.S.C. 1730C to permit the authorization of health care practices by health care professionals at VA pursuant to 38 U.S.C. 303, 501, and 7403.

Thus the VA Secretary has the authority to authorize by regulation the practice of telehealth by the VA health care professionals listed in 38 U.S.C. 7401 and by VA health care professional trainees appointed under 38 U.S.C. 7405 or 7406.

We also received a comment from the National Board for Certification in Occupational Therapy and another from the Federation of State Boards of Physical Therapy, however, these comments were received outside the 30-day comment period. These commenters may submit a comment during the rulemaking's notice and comment period. We received a response from the National Association of State Directors of Veterans Affairs, however, we consider these comments outside the scope of this rulemaking and do not make any changes based on these comments.

Paperwork Reduction Act

This proposed 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 proposed 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. The provisions associated with this rulemaking are not processed by any other entities outside of VA. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Executive Orders 12866, 13563

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 not a significant regulatory action under Executive Order 12866. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at *www.regulations.gov.*

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 proposed rule will have no such effect on State, local, and tribal governments, or on the private sector.

Assistance Listing

The Assistance Listing 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

Denis McDonough, Secretary of Veterans Affairs, approved this document on July 21, 2022, 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.

Consuela Benjamin,

Regulations Development Coordinator, Office of Regulation Policy & Management, Office of General Counsel, Department of Veterans Affairs.

For the reasons set forth in the preamble, the Department of Veterans Affairs proposes to amend 38 CFR part 17 as set forth below:

PART 17—MEDICAL

■ 1. The authority citation for part 17 is amended by revising the authority for § 17.417 to read 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, 1730C, 7301, 7306, 7330A, 7331, 7401–7403, 7405, 7406, 7408.

* * * * *

■ 2. Amend § 17.417 by:

■ a. Revising the section heading and paragraphs (a)(2) and (b); and

■ b. In paragraph (c), removing the term ''health care providers''' and adding in its place the term ''health care professionals'' wherever it appears.

The revisions read as follows:

§ 17.417 Health care professionals practicing via telehealth.

(a) * * *

(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 required to adhere to all standards for quality relating to the provision of health care in accordance with applicable VA policies;

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

(iv) 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 to practice the health care profession of the health care professional;

(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 paragraph (a)(2)(iv)(A)–(C) of this section and is either:

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

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

* * * * *

(b) *Health care professional's practice via telehealth.* (1) When a State law, license, registration, certification, or other State requirement is inconsistent with this section, the health care professional is required to abide by their federal duties and requirements. No State shall deny or revoke the license, registration, or certification of a covered health care professional who otherwise meets the qualifications of the State for holding the license, registration, or certification on the basis that the covered health care professional has engaged or intends to engage in activity covered under this section.

(2) VA health care professionals may practice their health care profession within the scope of their federal duties in any State irrespective of the State or location within a State where the health care professional or the beneficiary is physically located, if the health care professional is using telehealth to provide health care to a beneficiary.

(3) Health care professionals' 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, regulation, and policy.

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

(i) The beneficiary and the health care professional 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 professional's State of licensure, registration, or certification;

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

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

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

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

(vii) The beneficiary has verbally agreed to participate in telehealth but has not provided VA with a signed written consent.

* * * * *

[FR Doc. 2022–18033 Filed 8–22–22; 8:45 am]

BILLING CODE 8320–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R4–OAR–2022–0226; FRL–10161–01–R4]

Air Plan Approval; South Carolina; Revisions To Startup, Shutdown, and Malfunction Rules

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: The Environmental Protection Agency (EPA) is proposing to approve a State Implementation Plan (SIP) revision submitted by the State of South Carolina, through the South Carolina Department of Health and Environmental Control (SC DHEC), on November 4, 2016. This revision was submitted by South Carolina in response to a finding of substantial inadequacy and SIP call published by EPA on June 12, 2015, of provisions in the South Carolina SIP related to excess emissions during startup, shutdown, and malfunction (SSM) events. EPA is proposing approval of the SIP revision and proposing to determine that the revision corrects the deficiencies identified in the June 12, 2015, SIP call. EPA is also proposing to approve portions of multiple SIP revisions previously submitted by SC DHEC on October 1, 2007, July 18, 2011, August 8, 2014, and August 12, 2015, as they relate to the provisions identified in the June 12, 2015, SIP call.

DATES: Comments must be received on or before September 22, 2022.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–R4–OAR–2022–0226 at *www.regulations.gov.* Follow the online instructions for submitting comments. Once submitted, comments cannot be edited or removed from *regulations.gov.* EPA may publish any comment received to its public docket. Do not electronically submit any information you consider to be Confidential Business Information (CBI) or other information, the disclosure of which is restricted by statute. Multimedia submissions (audio, video, etc.) must be accompanied by a written comment. The written comment is considered the official comment and should include discussion of all points you wish to make. EPA will generally not consider comments or comment contents located outside of the primary submission (*i.e.,* on the web, cloud, or other file sharing system). For additional submission methods, the full EPA public comment policy, information about CBI or multimedia submissions, and general guidance on making effective comments, please visit *www.epa.gov/dockets.*

FOR FURTHER INFORMATION CONTACT: Estelle Bae, Air Permits Section, Air Planning and Implementation Branch, Air and Radiation Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street SW, Atlanta, Georgia 30303–8960. Ms. Bae can be reached by telephone at (404) 562–9143 or via electronic mail at *bae.estelle@epa.gov.*

SUPPLEMENTARY INFORMATION:

Table of Contents

I. Background

On February 22, 2013, EPA issued a **Federal Register** notice of proposed rulemaking (NPRM) outlining EPA's policy at the time with respect to SIP provisions related to periods of SSM. EPA analyzed specific SSM SIP provisions and explained how each one either did or did not comply with the Clean Air Act (CAA) with regard to