extruded form for use in manufacture; packing, stopping and insulating materials; flexible pipes, tubes and hoses, not of metal.

18. Leather and imitations of leather; animal skins and hides; luggage and carrying bags; umbrellas and parasols; walking sticks; whips, harness and saddlery; collars, leashes and clothing for animals.

19. Materials, not of metal, for building and construction; rigid pipes, not of metal, for building; asphalt, pitch, tar and bitumen; transportable buildings, not of metal; monuments, not of metal.

20. Furniture, mirrors, picture frames; containers, not of metal, for storage or transport; unworked or semi-worked bone, horn, whalebone or mother-of-pearl; shells; meerschaum; yellow amber.

21. Household or kitchen utensils and containers; cookware and tableware, except forks, knives and spoons; combs and sponges; brushes, except paintbrushes; brush-making materials; articles for cleaning purposes; unworked or semi-worked glass, except building glass; glassware, porcelain and earthenware.

22. Ropes and string; nets; tents and tarpaulins; awnings of textile or synthetic materials; sails; sacks for the transport and storage of materials in bulk; padding, cushioning and stuffing materials, except of paper, cardboard, rubber or plastics; raw fibrous textile materials and substitutes therefor.

23. Yarns and threads for textile use.

24. Textiles and substitutes for textiles; household linen; curtains of textile or plastic.

25. Clothing, footwear, headwear.

26. Lace and embroidery, and haberdashery ribbons and bows; buttons, hooks and eyes, pins and needles; artificial flowers; hair decorations; false hair.

27. Carpets, rugs, mats and matting, linoleum and other materials for covering existing floors; wall hangings, not of textile.

28. Games, toys and playthings; video game apparatus; gymnastic and sporting articles; decorations for Christmas trees.

29. Meat, fish, poultry and game; meat extracts for culinary purposes; preserved, frozen, dried and cooked fruits, vegetables and seaweeds; jellies, jams, compotes; eggs; milk, cheese, butter, yogurt and other milk products; oils and fats for food.

30. Coffee, tea, cocoa and substitutes therefor; rice, pasta and noodles; tapioca and sago; flour and preparations made from cereals; bread, pastries and confectionery; chocolate; ice cream, sorbets and other edible ices; sugar, honey, treacle; yeast, baking-powder; salt, seasonings, spices, preserved herbs; vinegar, sauces and other condiments; ice (frozen water).

31. Raw and unprocessed agricultural, aquacultural, horticultural and forestry products; raw and unprocessed grains and seeds; fresh fruits and vegetables, fresh herbs; natural plants and flowers; bulbs, seedlings and seeds for planting; live animals; foodstuffs and beverages for animals; malt.

32. Beers; non-alcoholic beverages; mineral and aerated waters; fruit beverages and fruit juices; syrups and other preparations for making non-alcoholic beverages.

33. Alcoholic beverages, except beers; alcoholic preparations for making beverages.

34. Tobacco and tobacco substitutes; cigarettes and cigars; electronic cigarettes and oral vaporizers for smokers; smokers' articles; matches.

Services

35. Advertising; business management, organization and administration; office functions.

36. Financial, monetary and banking services; insurance services; real estate services.

37. Construction services; installation and repair services; mining extraction, oil and gas drilling.

38. Telecommunications services.

39. Transport; packaging and storage of goods; travel arrangement.

40. Treatment of materials; recycling of waste and trash; air purification and treatment of water; printing services; food and drink preservation.

41. Education; providing of training; entertainment; sporting and cultural activities.

42. Scientific and technological services and research and design relating thereto; industrial analysis, industrial research and industrial design services; quality control and authentication services; design and development of computer hardware and software.

43. Services for providing food and drink; temporary accommodation.

44. Medical services; veterinary services; hygienic and beauty care for human beings or animals; agriculture, aquaculture, horticulture and forestry services.

45. Legal services; security services for the physical protection of tangible property and individuals; dating services, online social networking services; funerary services; babysitting.

John A. Squires,

Under Secretary of Commerce for Intellectual Property and Director of the United States Patent and Trademark Office.

[FR Doc. 2025–19358 Filed 10–1–25; 8:45 am]

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DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

[Docket No. VA–2022–VHA–0020]

RIN 2900–AQ59

Health Care Professionals Practicing Via Telehealth

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs (VA) adopts as final, with changes, a proposed rule to amend its medical regulations that govern VA's health care professionals who practice health care via telehealth. This final rule implements the authorities of the VA MISSION Act of 2018 and the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021. This final rule enables VA to maximize health care resource utilization and provide safe and convenient national health care to veterans using telehealth. It also strengthens VA's role in supporting national and State responses to war, terrorism, national emergencies and natural disasters.

DATES: This rule is effective November 3, 2025.

FOR FURTHER INFORMATION CONTACT: Dr. Kevin Galpin, Executive Director, Telehealth Services, Office of Connected Care, Veterans Health Administration, (404) 771–8794.

SUPPLEMENTARY INFORMATION: In a document published in the **Federal Register** (FR) on August 23, 2022, VA proposed to revise its regulations that govern a VA health care professional's practice via telehealth. 87 FR 51625. VA provided a 60-day comment period, which ended on October 24, 2022. We received a total of 18 comments, ten of which fully supported the proposed rule. We thank the commenters for their comments and do not further address them below. The remaining comments, some of which were generally supportive of the rule, raised issues and concerns that are grouped together by like topic and addressed below. We make minor changes to the rule as described below.

Comments Related to Preemption of State Law

We received two comments regarding VA's preemption of conflicting State laws. One commenter stated that VA is prohibited by the Tenth Amendment of the Constitution from requiring States to issue or continue licenses to health care professionals who do not meet State licensing requirements, such as the requirement that the health care professional's supervisor is providing in person supervision or the requirement that the trainee be supervised by a health care professional who is licensed in the same State as the trainee. The commenter requested that VA clarify that it is not commandeering States to license those employees who do not meet State requirements for a license. We do not make any changes based on the comment.

The Tenth Amendment of the United States Constitution provides that the powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people. However, VA's authority to furnish health care to veterans has not been reserved to the States or the people. Under Article I, section 8, Congress has the power to ''provide for the common Defence and general Welfare of the United States''; to ''raise and support Armies'', and to ''provide and maintain a Navy''; and to ''make Rules for the Government and Regulation of the land and naval Forces''. See Art. I, sec. 8, cls. 1, 12–14. Congress also has power to ''make all Laws which shall be necessary and proper for carrying into Execution the foregoing powers''. See Art. I, sec. 8, cls. 18. Congress exercises its authority under some or all of these clauses when enacting veterans' benefits. See, *e.g., Torres* v. *Texas Dep't of Pub. Safety,* 597 U.S. 580 (2022). Exercising these powers, Congress, under section 7301(b) of title 38, United States Code (U.S.C.), established 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. Generally, VA is allowed to employ medical professionals so long as they are licensed ''in a State,'' see, *e.g.,* 38 U.S.C. 7402(b)(1)(C), rather than in every State in which they or their patients will be located while providing care through VA. See also title 38, Code of Federal Regulations (CFR) 17.419(b)(1)(i) (providing that a VA health care professional may practice in any State ''irrespective of the State where they hold a valid license, registration, certification or other State qualification''). Specific to the provision of care through telehealth, Congress explicitly provided that, notwithstanding any provision of law regarding the licensure of health care professionals, a VA health care professional may practice at any location in any State, regardless of where the health care professional or the patient is located, when using telehealth to provide treatment to an individual under chapter 17. 38 U.S.C. 1730C(a). Section 1730C(d) further states that this section supersedes any State law to the extent that the State law is inconsistent with section 1730C, and that no State shall deny or revoke a license, registration, or certification who otherwise meets the qualifications of the State for holding such credential on the basis of their practice of telehealth at VA. Therefore, the rule does not encroach on any rights reserved to the States or to the people and is not a violation of the Tenth Amendment to the U.S. Constitution both because Congress has authority to enact laws regarding veterans' benefits under Article I, section 8, and because Congress asserted Federal supremacy under clause 2 of Article VI of the Constitution, which provides that the Constitution, and the laws of the United States made in pursuance thereof, are the supreme law of the land. In enacting section 1730C, Congress exercised its authority under this clause (commonly referred to as the supremacy clause) to preempt inconsistent State law.

We clarify that through this rulemaking, we are not requiring or commandeering a State to grant a license to those VA employees who do not meet the State requirements to receive a license, registration, certification, or other requirements. Rather, we are preempting any provisions of State requirements as applied to VA health care professionals to the extent that such provisions are inconsistent with a VA health care professional's practice via telehealth. If a State requirement is inconsistent with the VA employee's ability to carry out their Federal duties, that State requirement will have no force or effect on the VA employee when carrying out their VA duties. As explained above, section 1730C(d)(2) confirms that 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 telehealth at VA. However, the States will still determine whether the health care professional otherwise meets the State qualifications for holding the license, registration, or other requirement.

We received one comment addressing limitations in the Controlled Substances Act (CSA) and other applicable Federal law, regulation, and policy as applied to VA, to include possible limitation by State law through such authority. The commenter referenced practice guidelines regarding the prescribing of buprenorphine, citing 86 FR 22439 (April 28, 2021), that ordinarily require prescribers to be licensed to treat patients in the State in which the patient is located. As the commenter acknowledged, the practice guidelines specifically exempt Federal practitioners who are acting within the scope of their Federal employment. We do not make a substantive change based on the comment but make a non-substantive clarifying change to 38 CFR 17.417(b)(3) to avoid any potential confusion regarding the authority of VA health care professionals to prescribe controlled substances via telehealth and the impact of State law as referenced by Federal authority.

State law that would conflict with VA health care professionals prescribing via telehealth is not applicable to VA health care professionals, but Federal standards regarding prescribing via telemedicine are applicable. VA stated in proposed § 17.417(b)(3) that its health care professionals are subject to the CSA and other ''applicable Federal law, regulation, and policy,'' 87 FR 51631, whereas the provision it is replacing (currently in § 17.417(b)(1) requires health care professionals to comply with ''the laws and practice acts of the health care providers' State license, registration, or certification'' in addition to applicable Federal law. VA views the change as being authorized by, and consistent with, the relevant statutory authority.

Specifically, the CSA creates a number of standards for a prescription to be valid. See, *e.g.,* 21 U.S.C. 829. Additional standards are applicable to prescribing via ''telemedicine.'' See, *e.g.,* 21 U.S.C. 802(54) (authorizing prescribing a controlled substance when the prescriber is, inter alia, communicating with the patient via ''a telecommunications system referred to in section 1395m(m) of title 42.''). These standards created by the CSA are among the applicable Federal laws addressed in proposed 38 CFR 17.417(b)(3).

The CSA also references ''applicable . . . State laws'' into the ''practice of telemedicine.'' 21 U.S.C. 802(54). VA

health care professionals are specifically authorized to practice medicine through telehealth notwithstanding State law. 38 U.S.C. 1730C(a). VA does not view a conflict as existing between the two provisions. See *Morton* v. *Mancari,* 417 U.S. 535 (1974) (discussing the preference for reading statutes to co-exist if possible). Rather, section 1730C identifies a group of State laws—those that conflict with a covered health care professional's practice of health care through telehealth that are not appliable to VA health care professionals in their VA role—without specifically excluding State laws that interfere with prescribing controlled substances through telemedicine, whereas the CSA in section 802(54) identifies that health care professionals must generally comply with those State laws applicable to them. Section 1730C(d)(2) explicitly prohibits a State from denying or revoking the license, registration, or certification of a covered VA health care professional based on their practice of telehealth at VA.

Therefore, we conclude that it is possible to give effect to both 21 U.S.C. 802(54) and 38 U.S.C. 1730C, with the latter establishing that State laws interfering with VA health care professionals prescribing controlled substances are not applicable to VA health care professionals under the former. To the extent a conflict exists between the two statutes, we conclude that section 1730C(d) is the specific rule addressing State law as applied to the practice of telehealth by VA health care professionals and would control the general rule of 21 U.S.C. 802(54). See, *e.g., Morales* v. *Trans World Airlines, Inc.,* 504 U.S. 374, 384 (1992) (''[I]t is a commonplace of statutory construction that the specific governs the general.''). Moreover, 38 U.S.C. 1730C was enacted (in 2018) after 21 U.S.C. 802(54) (in 2008). To the extent there is a conflict, the canon of interpretation that the later statute will generally prevail over a conflicting earlier statute would also support VA's interpretation. Indeed, to do otherwise would effectively render 38 U.S.C. 1730C(d) surplusage with regard to prescribing via telemedicine, an interpretation that is not generally favored. See, *e.g., Montclair* v. *Ramsdell,* 107 U.S. 147, 152 (1883).

VA does not view section 1730C(e) as requiring a different result. Section 1730C(e) states a rule of construction that nothing in section 1730C may ''be construed to remove, limit, or otherwise affect any obligation of a covered health care professional under the [CSA]''). State law is superseded by section 1730C(a) (''notwithstanding any provision of law regarding the licensure of health care professionals'') to the extent it is inconsistent with a VA health care professional's practice of medicine through telehealth, with section 1730C(d) making clear that State may take no action against a VA health care professional's license based on a professional providing or intending to provide treatment through telehealth as part of their VA practice. Section 1730C(d)(1). In this context, such State laws are not ''applicable . . . State law'' under 21 U.S.C. 802(54) and create no ''obligation'' for VA health care professionals to follow conflicting State laws. 38 U.S.C. 1730C(e). Therefore, VA concludes that section 1730C(e) incorporates the Federal standards of the CSA, but not more. VA also notes that Congressional recognition of the unique nature of VA's Nationwide practice by removing some State-level requirements regarding prescribing is not unprecedented. For instance, in the CSA, Congress exempted VA health care professionals from some State requirements even before section 1730C was enacted. See, *e.g.,* 21 U.S.C. 802(54)(A)(ii)(III)(bb)(AA) (exempting VA health care professionals from the requirement of being ''registered . . . in the State in which the patient is located'' when prescribing via telehealth if the patient is being treated by, and physically located in, a hospital or clinic registered under 21 U.S.C. 823(g)).

This addition also supports VA's ''Fourth Mission'' 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's Fourth Mission is authorized under three separate authorities 38 U.S.C. 1784, 1784A, and 1785. Section 1784 authorizes VA to furnish hospital care or medical services as a humanitarian service in emergency cases. Under section 1784A, in the case of a VA hospital that has an emergency department, if any individual comes to the hospital or the campus of the hospital and a request is made on behalf of the individual for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. Lastly, under section 1785, VA may, during and immediately following a disaster or emergency, furnish hospital care and medical services to individuals responding to, involved in, or otherwise affected by that disaster or emergency. In conjunction with other Federal entities, such as the Department of Health and Human Services (HHS) and the Department of Defense, VA serves as an asset to the nation during disasters and emergencies. As a foundational part of Federal emergency management efforts through the National Response Framework, VA leads the effort for meeting veterans' needs and has expanded authority to assist service members or civilians. Telehealth and the ability to prescribe controlled substances in these situations are important capabilities to support VA's Fourth Mission. This rulemaking will ensure VA health care providers are able to practice according to Federal standards when prescribing controlled substances during emergencies to help support VA's Fourth Mission.

We considered whether our proposed rule made this point sufficiently clear to allow the public to meaningfully comment on the issue and conclude that the issue was sufficiently explained. In the preamble to the proposed rule VA now seeks to finalize, we explicitly addressed Executive Order 13132, which ''provides the requirements for preemption of State law when it is implicated in rulemaking.'' 87 FR 51627–51631. We further explained that VA health care professional's practice of health care via telehealth ''is subject to the limitations imposed by the Controlled Substances Act [. . .] and implementing regulations [. . .] 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.'' 87 FR 51625, 51626. See also id. at 51631 (proposed 38 CFR 17.417(b)(3)). This statement and corresponding regulatory text were intended to clarify that VA health care professionals are not excluded from Federal authority by 38 U.S.C. 1730C or the proposed rule, neither of which reference State law or suggest that the preemption of conflicting State laws does not extend to those State laws that are inconsistent with Federal standards regarding the prescription of controlled substances through telehealth.

We again note that this statement meaningfully departs from the existing regulation, which predates section 1730C. VA's initial efforts to preempt State law addressing the practice of telehealth prior to 1730C were not intended to exempt VA health care professionals from all State-law requirements. Specifically, VA engaged

in rulemaking in October 2017, publishing a proposed rule entitled Authority of Health Care Providers to Practice Telehealth. 82 FR 45756 (October 2, 2017). While conflicting State law was generally preempted (''this proposed rule would preempt certain State laws'', and ''conflicting State and local laws, rules, regulations, and requirements related to health care providers' practice would have no force or effect when practicing telehealth''), see id. at 45759, VA also stated that the rulemaking did not affect VA's existing requirement that all VA health care providers ''adhere to restrictions imposed by their State license, registration, or certification regarding the professional's authority to prescribe and administer controlled substances.'' Id. at 45758.

VA consulted with State officials before proposing the rule in 2017, with at least one response suggesting some varying interpretations about the scope of VA's rule to preempt State-law requirements interfering with VA's practice of telehealth as including controlled substances. Id. at 45760 (stating Florida's requirement that patients receive an in-person examination each time a physician issues a certification for medical marijuana would not apply to VA practitioners practicing telehealth, but VA would maintain the restrictions imposed by Federal law and policy regarding the prescription of controlled substances). See generally id. at 45759–60 (for a more fulsome discussion of the generally favorable input VA received from State agencies and National Associations for State practice groups).

In 2018, VA's rule was promulgated, 83 FR 21897 (May 11, 2018), and VA again clarified that this section ''does not otherwise grant health care providers additional authorities that go beyond what is required or authorized by Federal law and regulations or as defined in the laws and practice acts of the health care providers' State license, registration, or certification.'' Authority of Health Care Providers to Practice Telehealth, 83 FR 21897, 21898 (May 11, 2018). The version of 38 CFR 17.417(b)(1) that will be replaced is clear, therefore, both in plain language and regulatory history in directing compliance with prescribing requirements from a practitioner's State of licensure, save where there is a conflict with Federal duties or requirements.

Shortly after VA codified § 17.417 in regulation, 38 U.S.C. 1730C was enacted. MISSION Act of 2018, Public Law 115–182, sec. 151(a) (June 6, 2018). VA views section 1730C as a clear expansion of VA's authority to provide health care through telehealth. Congress made clear that VA health care professionals ''may practice'' their ''health care profession . . . at any location in any State, regardless of where'' the practitioner or patient were located when the practitioner was practicing via telehealth. 38 U.S.C. 1730C(a). State laws are superseded ''to the extent that such provision of State law [is] inconsistent,'' including that no State may ''deny or revoke the license, registration, or certification of a'' VA practitioner ''on the basis that the covered health care professional has engaged or intends to engage in activity covered by subsection (a).'' Id. at section 1730(d). While Congress made clear that VA health care professionals are subject to the provisions of the CSA in section 1730(e), it does not subject providers to the ''laws and practice acts of the health care providers' State license, registration, or certification'', unlike the VA regulation that was in effect. 38 CFR 17.417(b)(1). Following the enactment of the VA MISSION Act of 2018, VA published the proposed rule it now seeks to finalize. 87 FR 51625 (August 23, 2022). In the preamble to this proposed rule, VA stated that this proposed rulemaking would state that VA health care providers' practice of medicine via telehealth ''is subject to the limitations imposed by the Controlled Substances Act [. . .] and implementing regulations [. . .] 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.'' Id. at 51626. VA removed the current requirement for compliance with State-level restrictions in the providers' State of licensure, registration, or certification, echoing 38 U.S.C. 1730C, but did not address the change beyond the discussion above and the regulatory text stating that providers are subject to the CSA and ''other limitations on the provision of VA care set forth in applicable Federal law, regulation and policy.'' Id. at 51631 (proposed 38 CFR 17.417(b)(3)).

We explicitly address here and in updated § 17.417(b)(3) and clarify that this rulemaking supersedes any conflicting State requirements regarding the practice of telehealth, including such State or local laws, rules, regulations, and requirements related to the prescribing of controlled substances. This preemption applies both to the State's enforcement of these laws and to the CSA, to the extent the CSA could be read to reference State-level authority. See, *e.g.,* 21 U.S.C. 802(54) (defining ''practice of telemedicine'' as meaning ''in accordance with applicable Federal and State laws''). Conflicting State-level restrictions on the practice of telehealth are not applicable to VA health care professionals while those professionals are acting in the scope of their VA employment and practicing through telehealth, including to the extent that a State might otherwise take action regarding the license, registration, or certification of the provider. 38 U.S.C. 1730C(a), (d).

As articulated in our proposed rule, VA does not read section 1730C as removing requirements for prescribing via telehealth in the CSA or as set forth in other Federal law and policy. Section 1730C(e). Therefore, to the extent a Federal actor with authority to prescribe Federal standards, such as the U.S Department of Justice (including the Drug Enforcement Administration) or the Department of Health and Human Services, promulgate guidance binding on VA regarding the practice of telehealth, we view such authority as binding on VA health care professionals in their Federal practice. Additionally, any VA specific policies on prescribing controlled substances, *i.e.,* checking the Prescription Drug Monitoring Program, how many days of medication VA health care professional may prescribe, etc., must be followed. VA has a robust system in place for prescribing controlled substances and, as an integrated health system, has better substance use disorder service (SUDS) outcomes. These outcomes are achieved via VA's SUDS continuum of care, which provides standard outpatient services, intensive outpatient programs, opioid replacement therapies, residential rehabilitation and acute hospital services. VA has been proactive in developing initiatives and tools to ensure VA employed health care professionals deliver safe, high-quality care to veterans within its integrated health care system, be it through in-person or virtual care. By way of example, VA highlights its Opioid Safety Initiative (OSI), implemented Nationwide in 2013, which facilitates the safe, effective prescribing of opioid containing controlled substances in alignment with evidence-based practice.

Key outcomes from this initiative demonstrate its effectiveness. Between fourth quarter of Fiscal Year (FY) 2012 and fourth quarter of FY 2024, VA's achievements include:

- A 68% reduction in patients receiving opioids (874,897 to 282,346 patients);
- A 90% reduction in patients receiving opioids and benzodiazepines together (162,444 to 15,446 patients);

• An 82% reduction in patients with high dosage opioid therapy (greater than or equal to 90 Morphine Equivalent Daily Dose) (76,466 to 13,453 patients);
• A 73% reduction in patients on long-term opioid therapy (569,027 to 155,945 patients);
• A 53% increase in patients on long term opioid therapies with urine drug screen (UDS) (from 32% to 85%); and
• An 83% reduction in new patients on long-term opioid therapy (58,417 to 10,005 patients). (VHA internal OSI dashboard data).

Furthermore, VA mandates that all veterans have their care reviewed by an interdisciplinary team of health care professionals with expertise spanning pain, mental health, addiction, pharmacy and rehabilitation when the veteran:
• Is prescribed or has recently discontinued use of opioid analgesic medications and is identified as very high risk for overdose events, suicide events, or death through the VA's Stratification Tool for Opioid Risk Mitigation (STORM); or
• Has recently suffered from a non-fatal overdose.

Note: STORM estimates the risk of overdose or suicide events or death for all patients and has been incorporated in a decision support tool to support population management and individual patient risk review.

In a randomized program evaluation, this mandate was associated with a 22 percent reduction in all-cause mortality in the next 4 months among the very high-risk veterans targeted by this prevention program.[1] With VA's integrated health system and robust system in place for prescribing controlled substances, veterans who receive VA health care have better health outcomes than non-enrolled veterans, and VA hospitals have dramatically outperformed non-VA hospitals in overall quality ratings and patient satisfaction ratings.[2]

We also note that, in the FY 2024 budget request, VA included a legislative proposal addressing prescribing via telehealth. We view this request as complementary to the interpretation of 38 U.S.C. 1730C and 21 U.S.C. 802(54) articulated above. While State law is not applicable to VA health care professionals insofar as it is inconsistent with those professionals prescribing via telehealth, our legislative proposal provides further clarity regarding standards for quality and safety that VA would need to follow and establish in partnership with the Attorney General. Our legislative proposal provides additional clarity on VA's standards for prescribing via telehealth when doing so would be inconsistent with a State law that would be preempted by 38 U.S.C. 1730C.

We note that, in order to practice telehealth pursuant to section 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 undersection 7402(b), have qualifications for such profession as set forth by the Secretary. Trainees and postgraduate employees may only participate in telehealth with clinical supervision, which must be by an employee who is licensed, registered, or certified by a State or who otherwise meets qualifications as defined by the Secretary. See 87 FR 51629. In addition, all health care professionals that require a certification, registration, or other State requirement must maintain their credentials as outlined by VA's qualification standards in VA Handbook 5005, Staffing. VA health care professionals must still follow State laws, unless there is a conflict with Federal duties or requirements, and that pursuant to section 1730C(b)(1)(C), VA health care professionals are still ''required to adhere to all standards for quality relating to the provision of health care in accordance with applicable policies of the Department.'' We are amending 38 CFR 17.417(b)(4) by adding a new paragraph (b)(4)(viii) to add a new example of a situation where there would be a conflict between the health care professional's State license and Federal duties or requirements. This new paragraph states that an example 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 the beneficiary is receiving a controlled substance medication in a State other than the health care professional's State of licensure, registration, or certification. While several of the existing examples in § 17.417(b)(4) are relevant to prescribing controlled substances, VA believes a specific example adds clarity.

Another commenter raised concerns about the lack of public and State consultation prior to the promulgation of the rule. In particular, the commenter stated that promulgating health care professional practice rules at the Federal level rather than the State level reduces opportunities for public participation and limits public accountability, as the public can impact State laws and regulations governing licensed health care professionals as well as State regulating bodies. The commenter further explained that the State consultation process used for this rule was insufficient, as VA did not consult with individual State boards of nursing. We do not make any changes to the rule based on this comment.

As an initial matter, VA reiterates that Congress enacted 38 U.S.C. 1730C to specifically authorize VA to establish rules related to telehealth on a Federal level for VA health care professionals that would explicitly preempt State requirements that are inconsistent with VA's requirements. VA further believes that appropriate opportunities for public and State participation were available for this rule. VA provided a 60-day comment period on the proposed rule, which afforded the public, including State officials and individual State boards, the opportunity to submit comments on the rule. We also consulted with appropriate State officials, including the National Council of State Boards of Nursing, prior to the publication of the proposed rule in compliance with sections 4(d) and (e) and section 6(c) of Executive Order 13132, as that was the most practicable form of consultation. In addition, VA will continue to work closely with State licensing boards to make certain that VA health care professionals continue to meet the standards of clinical practice, which will ensure patient safety.

Comments Related to Employee Protections and State Licensing

We received several comments regarding how VA will protect VA health care professionals if a State pursues an adverse action against such professional for practicing via telehealth. While we do not consider any of these comments within the scope of the rule because they all concern internal VA processes, we will address the concerns to provide clarity and transparency. We do not make any changes based on these comments.

One commenter raised concerns that the rule does not explain how current and former VA employees should report

[1] See Strombotne KL, Legler A, Minegishi T, Trafton JA, Oliva EM, Lewis ET, Sohoni P, Garrido MM, Pizer SD, Frakt AB. Effect of a Predictive Analytics-Targeted Program in Patients on Opioids: A Stepped-Wedge Cluster Randomized Controlled Trial. J Gen Intern Med. 2022 May 2:1–7. doi: 10.1007/s11606–022–07617–y. Epub ahead of print. PMID: 35501628; PMCID: PMC9060407.

[2] *https://www.va.gov/wilmington-health-care/news-releases/400000-veterans-enrolled-in-va-health-care-over-past-365-days-30-increase-over-last-year/* and Eric A. Apaydin, et al. Veterans Health Administration (VA) vs. Non-VA Healthcare Quality: A Systematic Review. Journal of Internal Medicine, 38 (2023).

to VA State action that is being taken against their license based on activities undertaken within the scope of VA employment. While we do not consider any of this comment within the scope of the rule because it concerns internal VA processes, we will address the concern to provide clarity and transparency, as further described below. We do not make any changes based on this comment.

Multiple commenters raised concerns about how and whether VA would support or represent VA employees who have adverse actions taken against them for practicing via telehealth inconsistent with their State requirements. One commenter specifically raised concerns about how VA would protect postgraduate health care employees, health professions trainees, and those providing clinical supervision. Another commenter suggested that VA commit to assisting its employees from State action while another raised concerns about whether VA will devote resources, financial or otherwise, to employees in such instances. One of the commenters recommended that VA implement programs and procedures to protect employees who are acting within the scope of the rule. While we do not consider any of this comment within the scope of the rule because it concerns internal VA processes, we will address the concern to provide clarity and transparency. We do not make any changes based on this comment.

We emphasize that VA is committed to providing representation to all VA health care professionals who have any State action proposed or taken against them for practicing consistent with their Federal duties. VA health care professionals who carry out their Federal duties must be allowed to do so free from the threat of liability. The Supremacy Clause of the U.S. Constitution bars States and State officials from penalizing government personnel for performing their Federal functions, whether through State criminal prosecution, license revocation proceedings, or civil litigation unless authorized by Federal law. Subject to the requirements and procedures set forth in 28 CFR 50.15(a), Department of Justice representation is available to Federal employees in civil, criminal, and professional licensure proceedings where they face personal exposure for actions performed within the scope of their Federal duties. This includes representation of any postgraduate health care employees, health professional trainees, and those providing clinical supervision, as long as they meet the definition of health care professional in 38 CFR 17.417(a)(2). We note that such defense does not extend to situations where a State Board may be taking appropriate disciplinary action against a VA health care professional when their behavior or clinical practice substantially fails to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients or if the VA health care professional is practicing outside of the scope of their VA employment. This is consistent with VA's current practice.

Although VA is committed to protecting its health care professionals were any State to propose or take action against them, VA does not anticipate that many, if any, actions will be taken against its professionals for practicing via telehealth within the scope of their Federal duties. As previously explained, 38 U.S.C. 1730C(d) explicitly provides that the provisions of this section shall supersede any provisions of the law of any State to the extent that such provision of State law are inconsistent with this section and that 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 by subsection (a). Furthermore, State officials are barred from penalizing VA employees for performing their Federal duties, whether through criminal prosecution, license revocation, or civil litigation. See, *e.g.,* Intergovernmental Immunity for the Department of Veterans Affairs and Its Employees When Providing Certain Abortion Services, 46 Op. O.L.C., ____ at *10 (Sept. 21, 2022), *https://www.justice.gov/d9/2022-11/2022-09-21-va_immunity_for_abortion_services.pdf.*

One commenter raised a concern about whether VA or a future non-VA employer could take adverse employment action against the health care professional due to any proposed or actual State action against them. This commenter also stated that despite VA's preemption in this rule, a State regulatory body could still pursue action against a VA employee, which could prohibit such employee from working until the issue is resolved. While we do not consider any of this comment within the scope of the rule because it concerns internal VA processes, we will address the concern to provide clarity and transparency. We do not make any changes based on this comment.

VA will not take adverse employment action if a State proposes action against a VA health care professional solely on the basis of practicing consistent with their Federal duties. A State will typically not take immediate action against a health care professional whose practice is inconsistent with State law without first providing a professional due process. Thus, VA would have an opportunity to assist providers in their defense of any action proposed by a State as described above. In order to be employed at VA in certain health care professions, VA is statutorily required to ensure the health care professional has an active license, certification, registration, or other State requirement. Section 7402. If the health care professional does not meet these qualification standards, VA must remove the individual from a patient care position, *i.e.,* VA may move health care professionals to non-patient care positions, if necessary, while the professionals go through the process of defending their State license. VA would only take this action if a State has taken action against the health care professional's State license and the individual has no other active, current, unrestricted State license.

One commenter recommended VA include a provision in the final rule that allows VA to continue the employment of a health care professional whose licensure has been suspended, conditioned, or revoked when VA believes that the action is based on the employee's activities within the scope of their VA employment. Similar to the comments above we do not consider any of this comment within the scope of the rule because it concerns internal VA processes. We do not make any changes based on these comments.

Comments Related to the Definition of Health Care Professional

We received several comments related to the definition of health care professional in the regulation. Although one commenter specifically thanked VA for excluding contractors from the definition of health care professional, some commenters requested that VA include contractors under its definition of health care professional. One commenter suggested that contractors be included to ensure access to care. Another commenter stated that contractors are not expressly excluded under section 1730C; thus, there are no legal barriers to including them in the definition of health care professional. Another commenter suggested that VA could create a narrow exception to the exclusion of VA contractors from this rule in the instance when they are exempted under HHS's Practice Guidelines for the Administration of

Buprenorphine for Treating Opioid Use Disorder (HHS Practice Guidelines) from requiring supervision or collaboration with a Drug Enforcement Agency registered physician, even if required by State law.

VA stated in the proposed rule that VA-contracted health care professionals would be excluded from the definition of health care professional. VA maintains this exclusion because 38 U.S.C. 1730C requires that a health care professional be an employee of the Department appointed under 38 U.S.C. 7306, 7401, 7405, 7406, or 7408 or under title 5 and contracted health care professionals and community care professionals are not appointed under these authorities. We do not make any changes based on these comments.

Another commenter opposed amending the definition of health care professional to include postgraduate health care employees and health care professional trainees, as there may be ambiguity about which practice standards to follow, which could lead to unsafe patient care. We do not make any changes based on this comment. The definition of health care professional in section 1730C includes those who are postgraduate health care employees and those who are health professional trainees. See section 1730C(b)(2) and (3). Thus, VA is required by law to include such individuals in its definition of health care professional for purposes of telehealth.

One commenter suggested VA include certified registered nurse anesthetists (CRNA) in the definition of health care professional. We make no changes based on this comment. The proposed rule amended VA's definition of health care professional defined in 38 CFR 17.417(a)(2) to be consistent with the statutory definition found in 38 U.S.C. 1730C(b)(1)(A), which includes those appointed pursuant to section 7401. Section 7401(1) includes registered nurses. As CRNAs are advanced practice registered nurses appointed under section 7401, they are included in the definition of health care professional in section 1730C(b)(1)(A) and proposed 38 CFR 17.417(a)(2). This definition does not list specific health care professions, but rather lists the criteria that must be met to meet the definition of health care professional.

Comments Related to Quality of Care, Supervision, and Oversight

One commenter was generally supportive of the rule, but highlighted areas that VA should consider to ensure that VA provides the highest quality of care possible. The commenter was supportive of the rule's supervision requirement, but suggested that VA ensure that the proper level of supervision (*i.e.,* general, direct, or personal) and oversight is provided to both trainees as well as non-physician health care professionals.

We appreciate the suggestions from the commenter; however, we will not make any changes to the rule based on the comment. We agree with the commenter that the appropriate level of supervision should be required for trainees, but do not believe it is appropriate to define that level of supervision in this regulation. The level of supervision may depend on a variety of factors, in particular which health care occupation the trainee is practicing in, and therefore would be better determined sub-regulatorily. As to the commenter's concern about oversight, this is also beyond the scope of the rulemaking for similar reasons. However, as part of its telehealth expansion efforts, VA has developed and refined its telehealth policy to include telehealth oversight responsibilities that support access to safe, high quality services for veterans. VA will continue its efforts to enhance quality management and oversight practices.

Similarly, another commenter raised concerns about the lack of VA guidance, to include a lack of clear delineation for responsibility and oversight, regarding clinical supervision of nurses who have completed their education requirements but are not yet licensed.

While we appreciate this commenter's concerns regarding the need for clear guidance addressing supervisory requirements, we consider them beyond the scope of the proposed rule as they relate to internal VA processes. This rule codifies VA's statutory authority that VA trainees, such as student nurses and unlicensed postgraduate health care employees, may participate in telehealth under appropriate clinical supervision. It does not attempt to delineate or provide guidance on supervisory requirements based on different professions or a trainee's level of experience. VA will provide internal guidance to address the standards of practice that health care professionals should follow while practicing via telehealth. No changes are being made to the rule in response to this comment.

Comments Related to VA's National Standards of Practice and Sope of Practice

Multiple commenters addressed practice standards for various health care professional occupations. One commenter raised concerns about how quality of care would be affected were VA to increase the scope of practice of non-physician health care professionals when they practice via telehealth particularly, as the commenter asserts, that the clinical judgment of a non-physician health care professional cannot be substituted for that of a physician. Similarly, another commenter raised concerns regarding VA's development of national standards of practice. Another commenter recommended VA remove physician supervision requirements for CRNAs, particularly as such supervision does not impact patient safety and quality of care and instead may restrict access to care and increase costs.

These comments are beyond the scope of this rulemaking. VA has a separate regulatory authority at § 17.419 which authorizes it to develop national standards of practice for VA health care professionals via sub-regulatory guidance. Each national standard of practice will be posted on the **Federal Register** for a 60-day comment period prior to finalization and implementation. We encourage the commenters to provide their feedback regarding any potential change in the scope of practice of non-physician providers when they are posted for public feedback in the **Federal Register**.

Other Comments

One commenter recommended that VA correct the use of a comma after 21 CFR 1300 *et seq.* in 38 CFR 17.417(b)(3). The commenter stated that the implementing regulations should be cited as 21 CFR 1300 *et seq.* without a comma.

We disagree with the commenter, as the comma is used as a description of the citation 21 CFR 1300 *et seq.* Usually, if something or someone is sufficiently identified, such as the CFR citation, the description that follows is considered nonessential and should be surrounded by commas. However, we acknowledge that the proposed regulatory text at 38 CFR 17.417(b)(3) had a technical error as a comma was added after 21 U.S.C. 801. As part of this final rule, we are removing the comma after 21 U.S.C. 801 from the final regulation text in 38 CFR 17.417(b)(3).

A commenter appeared to highlight for VA that VA health care professionals and contractors are exempt from certain requirements from the Controlled Substances Act as a result of the HHS Practice Guidelines when prescribing controlled substances. The commenter seemed to further highlight that the exemption, while only in practice guideline, still retained the force and effect of law. The HHS Practice Guidelines provide an exemption from

certain statutory certification requirements related to training, counseling, and other ancillary services (*i.e.,* psychosocial services) to eligible physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives, who are State licensed and registered by the Drug Enforcement Agency to prescribe controlled substances. See 86 FR 22439. We presume that the commenter is suggesting VA update its regulation to include this exception from VA's adherence to the Controlled Substances Act. We are not making any changes based on this comment.

As noted by the commenter, the HHS Practice Guidelines were promulgated pursuant to 21 U.S.C. 823(h)(2)(B)(i)–(ii).[3] On December 29, 2022, the Consolidated Appropriations Act, 2023, was signed into law. Division FF, section 1262 of this Act repealed, among other subsections, 21 U.S.C. 823(h)(2)(B)(i)–(ii). Thus, because the statutory provisions granting HHS the authority to promulgate the practice guidelines have been repealed, they have no force or effect on VA health care providers. However, VA reiterates here that this rule preempts any State requirements regarding the practice of telehealth, including such State or local laws, rules, regulations, and requirements related to the prescribing of controlled substances.

Section 1730C(e) of title 38, U.S.C. provides that nothing in this section may be construed to remove, limit, or otherwise affect any obligation of a covered health care professional under the Controlled Substances Act. Similarly, 38 CFR 17.417(b)(3), provides that health care professionals' practice is subject to the Federal 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.

A commenter was also concerned with VA's prioritization of telehealth over in-person care, especially in instances when a patient is receiving acute hospital care in the home, as they alleged that substituting telehealth for in-person interactions can negatively impact patients, including their relationship with the health care professional, and should only be used when other options are unsafe. The commenter also opined that practicing via telehealth can be challenging for experienced health care professionals, even more so for student nurse trainees and unlicensed postgraduate Registered Nurses (RN). Another commenter supported telehealth but also noted there may be instances when telehealth should not be utilized and in-person care may be more appropriate.

As an initial matter, VA respects the decisions that veterans make as to their own health care decisions and does not force nor require any veteran to utilize telehealth if they would prefer an in-person appointment. Further, we disagree with the commenter that telehealth negatively impacts patients and their relationship with health care professionals, and we disagree that telehealth should only be used when other options are unsafe. Telehealth enhances VA's capacity to deliver essential and critical health care services to beneficiaries located in areas where health care professionals may be unavailable or to beneficiaries who may be unable to travel to the nearest VA medical facility for care because of their medical conditions. Telehealth increases the accessibility of VA health care, bringing VA medical services to locations convenient for beneficiaries, including clinics in remote communities and beneficiaries' homes. Our intent is not to replace visits that require in-person interactions with telehealth. VA must ensure that patient care is appropriate and safe. As such, a health care professional would determine if or when it would be appropriate for a patient who is receiving acute hospital care in the home to receive health care via telehealth. When clinically appropriate and preferred by a patient, telehealth is an important option to enhance health care access and convenience. With regards to the commenter's concern about the challenges of student nurse trainees and unlicensed postgraduate RNs practicing via telehealth, we note that these employees will be appropriately supervised and will benefit from exposure to telehealth during their training programs, which will better prepare them for practice upon graduation, as health care is provided via telehealth throughout the health care industry. No changes are being made to the rule in response to this comment.

Another commenter strongly encouraged VA to continue to build upon the Anywhere to Anywhere VA Health Care initiative, further deploying digital health innovations that will improve outcomes, reduce costs, and realize an improved caregiver experience and utilizing every opportunity to achieve a truly connected continuum of care, especially for those in rural communities.

While we consider this outside the scope of this rulemaking, VA appreciates this comment, agrees with the importance of integrating connected care into VA's health care delivery model, and intends to remain an innovative leader in this area. No changes are being made to the rule based on this comment.

Technical Edits

VA is making a technical edit to the definition of telehealth in 38 CFR 17.417(a)(4). VA defines the term telehealth to mean the use of electronic information or telecommunications technologies to support clinical health care, patient and professional health-related education, public health, and health administration. VA notes that the term virtual health is used interchangeably with the term telehealth. As such, VA is making a non-substantive change to the definition of ''telehealth'' to add that ''the term virtual health has the same meaning as the term telehealth and can be used interchangeably.'' No other changes in the meaning of the definition of telehealth are made by this change.

VA is also making technical edits to capitalize the term ''federal'' in § 17.417(a)(2)(iv)(D)(*4*)(b)(1) and (2); correctly format the cross references to the Controlled Substances Act in § 17.417(b)(3)(i) and (iii); and to replace a hyphen with the word ''through'' in the reference contained in § 17.417(a)(2)(iv)(D). These were errors in the proposed rule, and making these technical edits will ensure consistency with **Federal Register** publishing guidelines.

Based on the rationale set forth in the Supplementary Information to the proposed rule and in this final rule, VA is adopting the proposed rule as final with the changes described in this rule.

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

[3] We noted that section 1262 of Division FF of the Consolidated Appropriations Act, 2023 references 21 U.S.C. 823(g). However, this is a clerical error, and the repealed portions of the statute are within 21 U.S.C. 823(h).

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 final rule preempts certain State laws, VA consulted with State officials prior to the publication of the proposed rule in compliance with sections 4(d) and (e), as well as section 6(c) of Executive Order 13132. VA also provided a 60-day comment period on the proposed rule, which allowed for the State officials to provide additional comments on the rule. On August 21, 2019, VA sent a letter to the following: National Association of Boards of Pharmacy, Association of State and Provincial Psychology Boards, National Governors Association, American Academy of Physicians Assistants, National Council of State Boards of Nursing, National Association of State Directors of Veterans Affairs, Association of Social Work Boards, 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. VA received 11 comments from the State officials, which were addressed in the proposed rule.

Executive Orders 12866, 13563, and 14192

VA examined the impact of this rulemaking as required by Executive Orders 12866 (Sept. 30, 1993) and 13563 (Jan. 18, 2011), which direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits. The Office of Information and Regulatory Affairs has determined that this rulemaking is a not significant regulatory action under Executive Order 12866, as supplemented by Executive Order 13563. This final rule is an Executive Order 14192 deregulatory action because it generates incremental cost savings, while also simplifying and standardizing telehealth licensing requirements for VA health professionals. The regulatory impact analysis associated with this rulemaking can be found as a supporting document at *www.regulations.gov.*

Paperwork Reduction Act

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

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. 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.

Unfunded Mandates

This final rule will not 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.

Congressional Review Act

Pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (known as the Congressional Review Act) (5 U.S.C. 801 *et seq.*), the Office of Information and Regulatory Affairs designated this rule as not satisfying the criteria under 5 U.S.C. 804(2).

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

Douglas A. Collins, Secretary of Veterans Affairs, approved this document on September 23, 2025, 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.

Taylor N. Mattson,

Alternate Federal Register Liaison Officer, Department of Veterans Affairs.

For the reasons set forth in the preamble, the Department of Veterans Affairs amends 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 in part as follows:

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

* * * * *

Section 17.417 also issued under 38 U.S.C. 1701 (note), 1709A, 1712A (note), 1722B, 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 (4) 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)(iii)(A) through (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.

* * * * *

(*4*) *Telehealth.* The term telehealth means the use of electronic information or telecommunications technologies to support clinical health care, patient and professional health-related education, public health, and health administration. The term virtual health has the same meaning as the term telehealth and can be used interchangeably.

(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) Prescribing controlled substances via telehealth.

(i) 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 chapter II, 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 statute, regulation, and policy.

(ii) State law, license, registration, certification, or other State requirements conflicting with a VA health care professional's prescribing of controlled substances via telehealth are not applicable laws for VA health care professionals practicing their health care profession within the scope of their Federal duties in any State.

(iii) State requirements conflicting with a VA health care professional's prescribing of controlled substances via telehealth are not applicable through the Controlled Substances Act, 21 U.S.C. 801 *et seq.,* and implementing regulations at 21 CFR chapter II, for health care professionals' practice insofar as statute or regulation refer to ''applicable State law''.

(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;

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

(viii) The beneficiary is receiving a controlled substance medication in a State other than the health care professional's State of licensure, registration, or certification.

* * * * *

[FR Doc. 2025–19324 Filed 10–1–25; 8:45 am]

BILLING CODE 8320–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R03–OAR–2024–0513; FRL–12075–02–R3]

Approval and Promulgation of Air Quality Implementation Plans; West Virginia; Revisions to Regulation for Control of Ozone Season Nitrogen Oxide Emissions

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: The Environmental Protection Agency (EPA) is approving a state implementation plan (SIP) revision submitted by the State of West Virginia. The revision pertains to West Virginia 45 Code of State Rules (CSR) 40 (WV rule) that establishes the nitrogen oxides (NO_X) ozone season limitations and requirements for non-electrical generating unit (EGU) large industrial boilers and combustion turbines that have a maximum design heat input of greater than 250 million British thermal units per hour (MMBtu/hr), as well as affected stationary internal combustion engines and cement manufacturing kilns. This action is being taken under the Clean Air Act (CAA).

DATES: This final rule is effective on November 3, 2025.

ADDRESSES: The EPA has established a docket for this action under Docket ID Number EPA–R03–OAR–2024–0513. All documents in the docket are listed on the website. Although listed in the index, some information is not publicly available, *e.g.,* confidential business information (CBI) or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the internet and will be publicly available only in hard copy form. Publicly available docket materials are available through *www.regulations.gov,* or please contact the person identified in the **FOR FURTHER INFORMATION CONTACT** section for additional availability information.

FOR FURTHER INFORMATION CONTACT: Bryan Cashman, Planning & Implementation Branch (3AD30), Air & Radiation Division, U.S. Environmental Protection Agency, Region III, Four