



DEPARTMENT OF VETERANS AFFAIRS

8320-01

38 CFR Part 17

RIN 2900-AP44

Advanced Practice Registered Nurses

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) is proposing to amend its medical regulations to permit full practice authority of all VA advanced practice registered nurses (APRNs) when they are acting within the scope of their VA employment. This rulemaking would increase veterans' access to VA health care by expanding the pool of qualified health care professionals who are authorized to provide primary health care and other related health care services to the full extent of their education, training, and certification, without the clinical supervision of physicians. This rule would permit VA to use its health care resources more effectively and in a manner that is consistent with the role of APRNs in the non-VA health care sector, while maintaining the patient-centered, safe, high-quality health care that veterans receive from VA. The proposed rulemaking would establish additional professional qualifications an individual must possess to be appointed as an APRN within VA. The proposed rulemaking would subdivide APRN's into four separate categories that include certified nurse practitioner, certified registered nurse anesthetist, clinical nurse specialist, and certified nurse-midwife. The proposed rulemaking would also provide the criteria under which VA may grant full practice authority to an APRN, and define the

scope of full practice authority for each category of APRN. VA intends that the services to be provided by an APRN in one of the four APRN roles would be consistent with the nursing profession's standards of practice for such roles.

DATES: Comments must be received by VA on or before [Insert date 60 days after date of publication in the FEDERAL REGISTER].

ADDRESSES: Written comments may be submitted: through <http://www.Regulations.gov>; by mail or hand-delivery to Director, Regulations Management (02REG), Department of Veterans Affairs, 810 Vermont Avenue, NW, Room 1068, Washington, DC 20420; by fax to (202) 273-9026. Comments should indicate that they are submitted in response to "RIN 2900-AP44-Advanced Practice Registered Nurses." Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1068, between the hours of 8 a.m. and 4:30 p.m., Monday through Friday (except holidays). Call (202) 461-4902 for an appointment. (This is not a toll-free number.) In addition, during the comment period, comments may be viewed online through the Federal Docket Management System (FDMS) at <http://www.Regulations.gov>.

FOR FURTHER INFORMATION CONTACT: Dr. Penny Kaye Jensen, Liaison for National APRN Practice, 810 Vermont Ave., N.W., Washington, D.C. 20420; (202) 461-6700. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION:

Section 7301 of title 38 United States Code (U.S.C.) establishes the Veterans Health Administration (VHA) within VA, and establishes that its primary function is to “provide a complete medical and hospital service for the medical care and treatment of veterans, as provided in this title and in regulations prescribed by the Secretary pursuant to this title.” 38 U.S.C. 7301(b). In carrying out this function, VHA has an obligation to ensure that patient care is appropriate and safe and its health care practitioners meet or exceed generally-accepted professional standards for patient care. The Secretary is responsible for the proper execution and administration of all laws administered by the Department and for the control, direction, and management of the Department, to include agency personnel and management matters. See 38 U.S.C. 303. To enable the Secretary to direct, control and manage VA, Congress authorized the Secretary “to prescribe all rules and regulations which are necessary or appropriate to carry out the laws administered by the Department and are consistent with those laws.” 38 U.S.C. 501(a). The Under Secretary for Health is directly responsible to the Secretary for the operation of VHA (38 U.S.C. 305(b)). Unless specifically otherwise provided, the Under Secretary for Health, as the head of VHA, is authorized to “prescribe all regulations necessary to the administration of the Veterans Health Administration,” subject to the approval of the Secretary. 38 U.S.C. 7304. To allow VA to carry out its medical care mission, Congress also established a comprehensive personnel system for certain medical employees in VHA, independent of the civil service rules. See Chapters 73 and 74 of title 38, U.S.C. The Secretary was granted express statutory authority to establish the qualifications for VA’s healthcare practitioners, determine the hours and conditions of employment, take disciplinary action against employees, and otherwise regulate the

professional activities of those individuals. 38 U.S.C. 7401-7464. As an integrated Federal health care system with the responsibility to provide comprehensive care under 38 U.S.C. 7301, it is essential that VHA wisely manage its resources and fully utilize the skills of its health care providers to the full extent of their education, training, and certification. By permitting APRNs throughout the VHA system a way to achieve full practice authority in order to provide advanced nursing services to the full extent of their professional competence, VHA would further its statutory mandate to provide quality health care to our nation's veterans. This proposed regulatory change to nursing policy would permit APRNs to practice to the full extent of their education, training and certification, without the clinical supervision or mandatory collaboration of physicians. Standardization of APRN full practice authority, without regard for individual State practice regulations, would help to ensure a consistent continuum of health care across VHA by decreasing the variability in APRN practice that currently exists across VHA as a result of disparate State practice regulations. As of March 7, 2016 CRNAs have full practice authority in 17 states, while CNPs have full practice authority in almost 50% of the nation, which includes 21 states and the District of Columbia.

It would also aid in fully maximizing VHA APRN staff capabilities, which would increase VA's capacity to provide timely, efficient, and effective primary care services, as well as other services. This would increase veteran access to needed VA health care, particularly in medically-underserved areas, as well as decrease the amount of time veterans spend waiting for patient appointments. In addition, standardizing APRN practice authority would enable veterans, their families, and caregivers to understand more readily the health care services that VA APRNs are authorized to provide. This

preemptive rule would increase access to care and reduce the wait times for VA appointments utilizing the current workforce already in place.

To ensure that VA would have available highly qualified medical personnel, Congress mandated the basic qualifications for certain health care positions, including registered nurses. Sections 7401 through 7464 of title 38, U.S.C., grant VA authority to regulate the professional activities of such personnel. To be eligible for appointment as a VA employee in a health care position covered by section 7402(b) (other than Director), of title 38, U.S.C., a person must, among other requirements, be licensed, registered or certified to practice their profession in a State. The standards prescribed in section 7402(b) establish only the basic qualifications necessary “[t]o be eligible for appointment” and do not limit the Secretary or Under Secretary for Health from establishing other qualifications for appointment, or additional rules governing such personnel. In particular, 38 U.S.C. 7403(a)(1) provides that appointments under Chapter 74 “may be made only after qualifications have been established in accordance with regulations prescribed by the Secretary, without regard to civil-service requirements.” In addition, 38 U.S.C. 7421(a) directs that, “[n]otwithstanding any law, Executive order, or regulation, the Secretary shall prescribe by regulation the hours and conditions of employment and leaves of absence of employees appointed under any provision of [chapter 74] [in the specifically numerated positions] in the Veterans Health Administration” (including registered nurses). As the head of VHA, the Under Secretary for Health has the duty to “prescribe all regulations necessary to the administration of the Veterans Health Administration,” subject to approval by the Secretary. 38 U.S.C. 7304; see also 38 U.S.C. 501. Pursuant to this authority, the Under Secretary for

Health is authorized to establish the qualifications and clinical practice standards of VHA's nursing personnel and to otherwise regulate their professional conduct.

To continue to provide high quality health care to veterans, VA is proposing to amend its regulations to allow APRNs to practice to the full extent of their education, training, and certification, regardless of individual State restrictions that limit such full practice authority, except for applicable State restrictions on the authority to prescribe and administer controlled substances, when such APRNs are acting within the scope of their VA employment. The proposed rule would use the term "full practice authority" to refer to the APRN's authority to provide advanced nursing services without the clinical oversight of a physician when that APRN is working within the scope of their VA employment. Such full practice authority would be granted by VA upon demonstrating that the established regulatory criteria are met. In addition, full practice authority would be granted appropriate to the clinical service setting.

This proposed rule is consistent with the recommendation of the Institute of Medicine (IOM) of the National Academy of Sciences to remove scope-of-practice barriers. Specifically, the 2010 IOM report, "The Future of Nursing: Leading Change Advancing Health," (IOM Report) available at <http://iom.nationalacademies.org/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx>, recommended that "[a]dvanced practice registered nurses (APRNs) should be able to practice to the full extent of their education and training." *Id.* at 9. More generally, the report stated that "[r]estrictions on scope of practice and professional tensions have undermined the nursing profession's ability to provide and improve both general and advanced care" and asserted that "[p]roducing a health care

system that delivers the right care—quality care that is patient centered, accessible, evidence based, and sustainable—at the right time will require transforming the work environment, scope of practice, education, and numbers and composition of America’s nurses.” *Id.* at 26. In addition, the proposed rule is consistent with the National Council of State Boards of Nursing (NCSBN) Consensus Model, as discussed in more detail later in this rulemaking. Significantly, many States already permit full practice authority of APRNs or are in the process of doing so. Under the proposed rulemaking, APRNs would not be authorized to replace or act as physicians or to provide any health care services that are beyond their clinical education, training, and national certification. The proposed rule would limit an APRN’s full practice authority to practice within the scope of their VA employment, and any APRN practice outside of VA employment would remain subject to applicable State laws, in the same manner as any other licensed VA practitioner in their private practice.

In this rulemaking, VA is proposing to exercise Federal preemption of State nursing licensure laws to the extent such State laws conflict with the full practice authority granted to VA APRNs while acting within the scope of their VA employment.

Preemption would be the minimum necessary action for VA to allow APRNs full practice authority. It would be impractical for VA to lobby to each State that does not allow full practice authority to APRNs to change their laws regarding full practice authority. This process would be costly and time consuming for VA and would not guarantee the desired result of full practice authority to all APRNs.

Section-by-section Analysis of the Proposed Rule

17.415 Full practice authority for advanced practice registered nurses

The general qualifications for a person to be appointed as a VA nurse are found in 38 U.S.C. 7402(b)(3), which requires that a person must have successfully completed a full course of nursing in a recognized school of nursing, as well as be registered as a graduate nurse in a State. VA interprets “a recognized school of nursing” to mean a school of professional nursing approved by the appropriate State agency and accredited by the National League for Nursing Accrediting Commission (NLNAC) or the Commission on Collegiate Nursing Education (CCNE); the completion of coursework equivalent to a nursing degree in a MSN Bridge Program that qualifies for professional nursing registration; or a foreign school of professional nursing that enables the graduate to obtain current, full, active and unrestricted registration. VA Handbook 5005/27, Part II, Appendix G6, paragraph 2, Section B.a(2). VA interprets “registered as a graduate nurse in a state” to mean a current, full, active and unrestricted licensure, registration or certification as a graduate professional nurse in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the U.S. or in the District of Columbia (hereinafter “licensure”). Id. Pursuant to the authorities in 38 U.S.C. sections 7401 through 7464 and VA’s rulemaking authorities at 38 U.S.C. 501 and 7304, VA is proposing a new § 17.415(a), which would define additional qualifications a registered nurse must possess to be appointed to one of four (4) APRN roles, i.e., Certified Nurse practitioner (CNP), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), or Certified Nurse-Midwife (CNM). The proposed rule would require an advanced practice registered nurse to have successfully completed a nationally-accredited, graduate-level educational program that prepares the advanced practice registered

nurse in one of the four APRN roles; and to possess, and maintain, national certification and State licensure in that APRN role. These additional qualifications are derived from criteria set forth in the IOM Report, and the National Council of State Boards of Nursing Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education) Regulation, July 2008 (the APRN Consensus Model), which VA finds to be the criteria most widely accepted by State boards of nursing and the nursing community as necessary to practice as an APRN. Under the proposed rule, APRNs who meet these additional qualifications may be granted full practice authority within VA in one of the four recognized APRN roles.

Proposed § 17.415(a)(1) would require an APRN to have successfully completed an accredited graduate-level educational program in one of the four distinct APRN roles. The Consensus Model defines these roles as CNP, CRNA, CNS, and CNM. These APRN roles are widely known and accepted by State boards of nursing and the nursing community. VA currently does not employ CNMs; however, the proposed rule includes CNMs in the event that VA has the need to hire CNMs in the future.

Proposed § 17.415(a)(2) would require an APRN to have passed a national certification examination that measures the APRN's knowledge, skills and experience demonstrated by the achievement of standards identified by the profession in one of the four APRN roles established in proposed § 17.415(a)(1). Public and private sector health care employers, State boards of nursing, and the nursing community rely on national certification through an examination process as the standard, which conveys adequate APRN knowledge, and VA's regulation would adopt the same standard.

Proposed § 17.415(a)(3) would require an APRN to possess a license from a State licensing board in one of the four recognized APRN roles. Proposed § 17.415(a)(4) would require an APRN to maintain both the national certification and licensure required in proposed paragraphs (a)(2) and (3) of § 17.415.

In total, proposed paragraphs (a)(1) through (4) of § 17.415 would establish qualifications for employment within VA as a CNP, CRNA, CNS and CNM. These qualifications would ensure that VA APRNs possess and maintain the education, knowledge, national certification and State licensure necessary for VA employment in one of the four recognized APRN roles. APRNs who meet these qualifications would be granted full practice authority within VA in one of the four recognized APRN roles.

Proposed § 17.415(b) would define “full practice authority” to mean that an APRN working within the scope of VA employment would be authorized to provide the services described in proposed § 17.415(d), without the clinical oversight of a physician, regardless of State or local law restrictions on that authority. Further, any APRN practice established outside VA employment would be subject to applicable State law, in the same manner as private practice by any other licensed VA provider.

Proposed § 17.415(c) would establish the criteria by which VA may grant full practice authority to an APRN. Proposed paragraph (c)(1), would require a VA medical facility to verify that the APRN meets the requirements established in proposed § 17.415(a). Proposed paragraph (c)(2) would require VA to confirm that the APRN has demonstrated the knowledge and skills necessary to provide the services described in proposed § 17.415(d) without the clinical oversight of a physician, and is thus qualified to be privileged for such scope of practice. Proposed § 17.415(c)(1) and (2) together

would clarify that the VA processes for credentialing and privileging of licensed independent health care providers would apply to VA APRNs with full practice authority. VA anticipates that the granting of full-practice authority under proposed § 17.415(c) would be implemented through formal VHA guidance issuances.

Proposed § 17.415(d)(1) would describe the role-specific services that a VA APRN would be authorized to perform under their full practice authority. This authority would be without regard to state licensure restrictions, except as provided in proposed paragraph (d)(2), which would defer to State licensure restrictions on a VA APRN's authority to prescribe, or administer controlled substances. We emphasize that full practice authority for an APRN in this rulemaking would apply only to services provided by an APRN when working within the scope of their VA employment, as required by proposed § 17.415(b). Additionally, all full practice authority of APRNs in proposed § 17.415(d)(1) would be under approved privileges by, and within the available resources of, a VA medical facility, as required by proposed § 17.415(c). VA intends that the services to be provided by an APRN in one of the four APRN roles would be consistent with the nursing profession's standards of practice for such roles.

In proposed § 17.415(d)(1)(i), a CNP would have full practice authority to provide the following services: comprehensive histories, physical examinations and other health assessment and screening activities; diagnose, treat, and manage patients with acute and chronic illnesses and diseases; order, perform, supervise, and interpret laboratory and imaging studies; prescribe medication and durable medical equipment and; make appropriate referrals for patients and families; and aid in health promotion, disease

prevention, health education, and counseling as well as the diagnosis and management of acute and chronic diseases.

In proposed § 17.415(d)(1)(ii), a CRNA would have full practice authority to provide a patient's anesthesia care and anesthesia related care, to include planning and initiating anesthetic techniques (general, regional, local) and sedation, providing post-anesthesia evaluation and discharge; ordering and evaluating diagnostic tests; requesting consultations; performing point-of-care testing; and responding to emergency situations for airway management.

In proposed § 17.415(d)(1)(iii), a CNS would have full practice authority to provide diagnosis and treatment of health or illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities within their scope of practice.

Lastly, in proposed § 17.415(d)(1)(iv), a CNM would have full practice authority to provide a full range of primary health care services to women veterans, including gynecologic care, family planning service, preconception care (care that women veterans receive before becoming pregnant, including reducing the risk of birth defects and other problems such as the treatment of diabetes and high blood pressure), prenatal and postpartum care, childbirth, and care of a newborn. We note that the pregnancy and delivery services described above, as well as the newborn care services, would be subject to the limitations established in 38 CFR 17.38(a)(1)(xiii) and (xiv), respectively. We also note that authorized CNM services would include treating the partner of the female patient for sexually transmitted infection and reproductive health, if the partner is enrolled in the VA healthcare system or not required to enroll to

receive VA services. We would include the services of a CNM in this rulemaking in anticipation that VA would hire CNMs at a future date to improve access to health care for the increasing number of female veterans.

Proposed § 17.415(d)(2) would expressly limit full practice authority. Congress has specifically required reliance on a specific State law under the Controlled Substance Act (CSA). Specifically, proposed § 17.415(a)(2) would provide that full practice authority within VA is subject to State licensure law with regard to the authority of an APRN to prescribe, or administer controlled substances, and to any other limitations on the provision of VA care set forth in applicable Federal law and policy. Regarding the full practice authority limitations for controlled substances, the CSA, 21 U.S.C. 801 *et seq.*, and implementing regulations in 21 CFR part 1300, make State licensure authority to prescribe, or administer controlled substances a prerequisite for authority under the CSA to prescribe, or administer controlled substances. See 21 U.S.C. 802(21) (providing that a practitioner must be “licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which he practices or does research, to distribute, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.”); See also 21 CFR 1306.03(a) (stating that a prescription for a controlled substance may be issued only by an individual practitioner who is: (1) authorized to prescribe controlled substances by the jurisdiction in which he is licensed to practice his profession and (2) either registered or exempted from registration pursuant to §§ 1301.22(c) and 1301.23.). Proposed § 17.415(d)(2) also would make the full practice

authority of an APRN subject to any other limitations on the provision of VA care set forth in Federal law or policy.

Proposed § 17.415(e) would expressly state the intended preemptive effect of proposed § 17.415, to ensure it is clear that conflicting State and local laws related to the practice of APRNs would have no force or effect when such APRNs are working within the scope of their VA employment. In circumstances where there is a conflict between Federal and State Law, Federal law prevails in accordance with Article VI, clause 2, of the U.S. Constitution (Supremacy Clause). It is a well-established principle of constitutional law that Federal law is supreme, and States may not regulate or control the lawful actions of the Federal Government, absent Congressional consent.

Therefore, where there is conflict between State law and Federal law with regard to full practice authority of APRNs working within the scope of their federal VA employment, this regulation would control. Accordingly, State disciplinary actions that would penalize, or otherwise interfere with, an APRN's full practice authority in the performance of their official VA duties, would likewise be effectively preempted.

However, where there is no conflict between this regulation and State law, the State would retain authority to impose State regulations on its APRN licensees and take disciplinary action for any violations. We emphasize that this preemptive effect would only pertain to APRNs when they are acting within the scope of their federal VA employment; this rule would not have any effect on individual State efforts to either permit or restrict full practice authority for APRNs who are not working within a VA scope of employment.

The Indian Health Service already grants full practice authority to APRNs. See Part 4, Chapter 3, Section 11, “Advanced Practice Nurses,” Indian Health Manual. In the Military Health System, the Services employ APRNs, which includes Nurse Midwives, Nurse Practitioners, and Nurse Anesthetists, in independent practice without oversight from physicians. They are privileged in their roles as APRNs and can adjust their scope practice (level of care) through privileging as granted by a committee of physicians and the military treatment facility commander. Nurse Practitioners specifically have an assigned group of patients for which they are responsible. Therefore, we do not anticipate that the proposed changes in this rulemaking would be completely novel or unexpected to the general public or other Federal entities that provide health care services to beneficiaries.

Executive Order 13132, Federalism

Section 4 of Executive Order 13132 (titled “Federalism”) requires an agency that is publishing a regulation that preempts State law to follow certain procedures. Section 4(b) of the Executive Order requires agencies to “construe any authorization in the statute for the issuance of regulations as authorizing preemption of State law by rulemaking only when the exercise of State authority directly conflicts with the exercise of Federal authority under the Federal statute or there is clear evidence to conclude that the Congress intended the agency to have the authority to preempt State law.” Section 4(d) of the Executive Order requires that when an agency proposes to act through rulemaking to preempt State law, “the agency shall consult, to the extent practicable, with appropriate State and local officials in an effort to avoid such a conflict.” Section

4(e) of the Executive Order requires that when an agency proposes to act through rulemaking to preempt State law, “the agency shall provide all affected State and local officials notice and an opportunity for appropriate participation in the proceedings.”

Section 6(c) of Executive Order 13132 states that “no agency shall promulgate any regulation that has federalism implications and that preempts State law, unless the agency, prior to the formal promulgation of the regulation, (1) consulted with State and local officials early in the process of developing the proposed regulation; (2) in a separately identified portion of the preamble to the regulation as it is to be issued in the Federal Register, provides to the Director of the Office of Management and Budget a federalism summary impact statement, which consists of a description of the extent of the agency’s prior consultation with State and local officials, a summary of the nature of their concerns and the agency’s position supporting the need to issue the regulation, and a statement of the extent to which the concerns of State and local officials have been met; and (3) makes available to the Director of the Office of Management and Budget any written communications submitted to the agency by State and local officials.”

Because this regulation would address preemption of certain State laws, VA conducted prior consultation with State officials in compliance with Executive Order 13132. VA sent a letter to the National Council of State Boards of Nursing to state VA’s intent to allow full practice authority to VA APRNs and for the National Council of State Boards of Nursing to notify every State Board of Nursing of VA’s intent and to seek feedback from such Boards of Nursing.

In addition, VA solicited comments and input from State Boards of Nursing, through their representative national organization, the National Council of State Boards of Nursing (NCSBN). In response to its request for comments, VA received correspondence from the Executive Director and other relevant staff members within NCSBN, which agreed with VA's position that this rulemaking properly identifies the areas in VA regulations that preempt State laws and regulations. VA received no other comments from the NCSBN on this rulemaking. In response to VA's outreach to NCSBN, VA received numerous calls and correspondence from State and local officials in support of this proposed rule. Such State and local officials included State Senators from Georgia and Illinois, State Representatives from Florida, Ohio, Vermont, North Carolina, Georgia, and Illinois, County Commissioners from Nevada, Ohio, and North Carolina, and the State Comptroller and Secretary of State from Illinois, to name a few.

VA additionally engaged other relevant external groups on the proposed changes in this rulemaking, including the American Association of Nurse Anesthetists, American Association of Nurse Practitioners, American College of Surgeons, American Academy of Family Practice Physicians, American Society of Anesthesiologists, American Medical Association, Association of American Medical Colleges, The Joint Commission-Office of Accreditation and Certification, American Association of Retired Persons, American Legion, Blinded Veterans Association, Vietnam Veterans of America, American Women Veterans, Disabled American Veterans, Paralyzed Veterans of America, Veterans of Foreign Wars. VA also engaged the Senate and House Veterans Affairs Committees and the Senate and House Armed Services Committees.

Many external stakeholders expressed general support for VA's positions taken in this proposed rule, particularly with respect to full practice authority of APRNs in primary health care. However, we also received comments opposing full practice authority for CRNAs when providing anesthetics. To aid in VA's full consideration to this issue, VA encourages any comments regarding the proposed full practice authority. In this way, VA will be providing all affected State and local officials notice and an opportunity for appropriate participation in the proceedings.

VA's promulgation of this regulation complies with the requirements of Executive Order 13132 by (1) in the absence of explicit preemption in the authorizing statute, identifying where the exercise of State authority conflicts with the exercise of Federal authority under Federal statute; (2) limiting the preemption to only those areas where we find existence a conflict; (3) restricting the regulatory preemption to the minimum level necessary to achieve the objectives of the statute; (4) consulting with the State Boards of Nursing and other relevant external parties as indicated above; and (5) providing opportunity for comment through this rulemaking.

Effect of rulemaking

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

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 would not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. This proposed rule would directly affect only individuals and would not directly affect small entities. Therefore, pursuant to 5 U.S.C. 605(b), this amendment would be exempt from the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604.

Executive Orders 12866 and 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. Executive Order 12866 (Regulatory Planning and Review) defines a “significant regulatory action,” which requires review by OMB, as “any regulatory action that is likely to result in a rule that may: (1) Have an

annual effect on the economy of \$100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order.”

The economic, interagency, budgetary, legal, and policy implications of this proposed rule have been examined, and it has been determined to be a significant regulatory action under Executive Order 12866. VA's impact analysis can be found as a supporting document at <http://www.regulations.gov>, usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its impact analysis are available on VA's Web site at <http://www.va.gov/orpm/>, by following the link for “VA Regulations Published From FY 2004 Through Fiscal Year to Date.”

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100 million or more (adjusted annually for

inflation) in any one year. This proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are: 64.007, Blind Rehabilitation Centers; 64.008, Veterans Domiciliary Care; 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; 64.014, Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; 64.022, Veterans Home Based Primary Care; and 64.024, VA Homeless Providers Grant and Per Diem Program.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Robert L. Nabors II, Chief of Staff, Department of Veterans Affairs, approved this document on January 6, 2016.

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, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Dated: May 20, 2016.

Michael Shores.
Acting Director,
Office of Regulation Policy & Management,
Office of Secretary,
Department of Veterans Affairs.

For the reasons set forth in the preamble, we propose to amend 38 CFR part 17 as follows:

PART 17 -- MEDICAL

1. The authority citation for part 17 continues to read as follows:

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

2. Amend part 17 by adding an undesignated center heading and § 17.415 immediately after § 17.410 to read as follows:

Nursing Services

§ 17.415 Full practice authority for advanced practice registered nurses.

(a) Advanced practice registered nurse (APRN). For purposes of this section, an advanced practice registered nurse (APRN) is an individual who:

(1) Has completed a nationally-accredited, graduate-level educational program that prepares them for one of the four APRN roles of Certified Nurse Practitioner (CNP), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), or Certified Nurse-Midwife (CNM);

(2) Has passed a national certification examination that measures knowledge in one of the APRN roles described in paragraph (a)(1) of this section;

(3) Has obtained a license from a State licensing board in one of four recognized APRN roles described in paragraph (a)(1) of this section; and

(4) Maintains certification and licensure as required by paragraphs (a)(2) and (3) of this section.

(b) Full practice authority. For purposes of this section, full practice authority means the authority of an APRN to provide services described in paragraph (d) of this section without the clinical oversight of a physician, regardless of State or local law restrictions, when that APRN is working within the scope of their VA employment.

(c) Granting of full practice authority. VA may grant full practice authority to an APRN subject to the following:

(1) Verification that the APRN meets the requirements established in paragraph (a) of this section; and

(2) Determination that the APRN has demonstrated the knowledge and skills necessary to provide the services described in paragraph (d) of this section without the clinical oversight of a physician, and is thus qualified to be privileged for such scope of practice.

(d) Services provided by an APRN with full practice authority. (1) Subject to the limitations established in paragraph (d)(2) of this section, the full practice authority for each of the four APRN roles includes, but is not limited to, providing the following services:

(i) A CNP has full practice authority to:

(A) Take comprehensive histories, provide physical examinations and other health assessment and screening activities, diagnose, treat, and manage patients with acute and chronic illnesses and diseases;

(B) Order, perform, supervise, and interpret laboratory and imaging studies;

(C) Prescribe medication and durable medical equipment;

(D) Make appropriate referrals for patients and families, and request consultations;

(E) Aid in health promotion, disease prevention, health education, and counseling as well as the diagnosis and management of acute and chronic diseases.

(ii) A CRNA has full practice authority to:

(A) Plan and initiate anesthetic techniques (general, regional, local) and sedation;

(B) Provide post-anesthesia evaluation and discharge;

(C) Order and evaluate diagnostic tests;

(D) Request consultations;

(D) Perform point-of-care testing; and

(E) Respond to emergency situations for airway management.

(iii) A CNS has full practice authority to provide diagnosis and treatment of health or illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities within their scope of practice.

(iv) A CNM has full practice authority to provide a range of primary health care services to women, including gynecologic care, family planning services, preconception care (care that women veterans receive before becoming pregnant, including reducing the risk of birth defects and other problems such as the treatment of diabetes and high blood pressure), prenatal and postpartum care, childbirth, and care of a newborn, and treating the partner of their female patients for sexually transmitted disease and

reproductive health, if the partner is also enrolled in the VA healthcare system or is not required to enroll.

(2) The full practice authority of an APRN is subject to the limitations imposed by the Controlled Substances Act, 21 U.S.C. 801 *et seq.*, and that APRN's State licensure on the authority to prescribe, or administer controlled substances, as well as any other limitations on the provision of VA care set forth in applicable Federal law and policy.

(e) Preemption of State and local law. To achieve important Federal interests, including but not limited to the ability to provide the same comprehensive care to veterans in all States under 38 U.S.C. 7301, this section preempts conflicting State and local laws relating to the practice of APRNs when such APRNs are working within the scope of their VA employment. Any State or local law, or regulation pursuant to such law, is without any force or effect on, and State or local governments have no legal authority to enforce them in relation to this section or decisions made by VA under this section.

(Authority: 38 U.S.C. 7301, 7304, 7402, and 7403)

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