The Proposed Rule Goes Against State Law and Trends

The VHA's proposal would undermine the 28 states that require nurse practitioners to collaborate with or be supervised by physicians. Currently only 22 states[1] and the District of Columbia allow nurse practitioners to practice completely independently, seven[2] of which allow nurse practitioners to practice independently only after the nurse practitioner has completed a certain amount of hours/years of clinical practice in collaboration with a physician. Another eight states[3] allow nurse practitioners to diagnose and treat independently, but require a collaborative agreement for purpose of prescribing. The remaining 20 states[4] require physician involvement for nurse practitioners to diagnose, treat, and prescribe. Even states that have granted independent practice in recent years have required transition periods that maintain the physician's oversight role for a certain amount of time.[5] Some states also created joint regulatory bodies (composed of members of the boards of medicine and nursing) that advise nursing boards on such issues as formularies and collaborative practice agreements or review nurse practitioner applications for independent practice. Taken together, these laws are a further indication that the Proposed Rule is misguided and out of step with state law and trends.

The Proposed Rule is also in conflict with the 21 states[6] that require nurse midwives to collaborate with or practice under the supervision of a physician, and six states[7] that require collaborative practice for purposes of a nurse midwife's prescriptive authority. Finally, the Proposed Rule is significantly out of step with 45 states and the District of Columbia, which require nurse anesthetists to practice with or be supervised by physicians.[8]

The Proposed Rule's Preemption Language Does not Accord with Federalism Policy

The Proposed Rule asserts that state or local laws relating to the practice of APRNs in the context of VHA employment are "without any force or effect," and that state and local governments "have no legal authority to enforce them." While the undersigned understand the Supremacy Clause justification cited in the preamble, the VHA's proposed regulatory preemption language is startlingly aggressive in light of both federal policy and the lack of underlying statutory preemption language in 38 U.S.C. 7301.

President Obama's preemption memorandum of May 20, 2009 specifically noted with approval that "state and local governments have frequently protected *health* [and] *safety* more aggressively than has the national government." The President's memorandum, therefore, announced that "preemption of state law

[1] AK, AZ, CO, CT, HI, IA, ID, MD, ME, MN, MT, ND, NE, NH, NM, NV, OR, RI, VT, WA, WV, WY.
[2] CT, MD, MN, NE, ME, VT, WV.
[3] AR, KY, MA, NJ, OK, TX, UT.
[4] AL, CA, DE, FL, GA, IL, IN, KS, LA, MO, MS, NC, NY, OH, PA, SC, SD, TN, VA, WI.
[5] See CT Governor's Bill 36 (Session Year 2014); MD House Bill 999 (2015 Regular Session); MI Senate File 511 (88th Session); NB Legislative Bill 107 (2015-2016 Session); NV Assembly Bill 170 (77th Session); NY Assembly Bill 4846 (2013-2014 Regular Session); and WV House Bill 4334 (2016 Regular Session).
[6] AL, AR, CA, FL, GA, IL, IN, KS, LA, MD, MS, MO, NE, NM, NC, OH, PA, SC, SD, VA, WI.
[7] DE, KY, MI, OK, TN, TX, WV.
[8] Only ID, MT, NH, OH, and UT allow CRNAs to practice independently. While 18 states have "opted out" of the federal requirement that physicians supervise anesthesia care for purposes of Medicare repayment, opting out of this requirement does not supersede state scope of practice laws.