

	Rating
(2) <i>Modified radical mastectomy</i> means removal of the entire breast and axillary lymph nodes (in continuity with the breast). Pectoral muscles are left intact.	
(3) <i>Simple (or total) mastectomy</i> means removal of all of the breast tissue, nipple, and a small portion of the overlying skin, but lymph nodes and muscles are left intact.	
(4) <i>Wide local excision</i> (including partial mastectomy, lumpectomy, tylectomy, segmentectomy, and quadrantectomy) means removal of a portion of the breast tissue.	
7627 Malignant neoplasms of gynecological system or breast .....	100
<b>Note:</b> A rating of 100 percent shall continue beyond the cessation of any surgical, X-ray, antineoplastic chemotherapy or other therapeutic procedure. Six months after discontinuance of such treatment, the appropriate disability rating shall be determined by mandatory VA examination. Any change in evaluation based upon that or any subsequent examination shall be subject to the provisions of §3.105(e) of this chapter. If there has been no local recurrence or metastasis, rate on residuals.	
7628 Benign neoplasms of the gynecological system or breast. Rate according to impairment in function of the urinary or gynecological systems, or skin.	
7629 Endometriosis:	
Lesions involving bowel or bladder confirmed by laparoscopy, pelvic pain or heavy or irregular bleeding not controlled by treatment, and bowel or bladder symptoms .....	50
Pelvic pain or heavy or irregular bleeding not controlled by treatment .....	30
Pelvic pain or heavy or irregular bleeding requiring continuous treatment for control .....	10
<b>Note:</b> Diagnosis of endometriosis must be substantiated by laparoscopy.	

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Health Care Financing Administration**

**42 CFR Parts 440 and 441**

**[MB-41-F]**

**RIN 0938-AF12**

**Medicaid Program; Required Coverage of Nurse Practitioner Services**

**AGENCY:** Health Care Financing Administration (HCFA), HHS.

**ACTION:** Final rule.

**SUMMARY:** This final rule stipulates the requirements for coverage of and payment for pediatric and family nurse practitioner services under the Medicaid program. The coverage of these additional services under the Medicaid program increases the availability and accessibility of medical care for specified Medicaid recipients.

This final rule adds to the Medicaid regulations provisions of sections 1902(a)(10)(A) and 1905(a)(21) of the Social Security Act, as amended by section 6405 of the Omnibus Budget Reconciliation Act of 1989.

**EFFECTIVE DATE:** These regulations are effective May 22, 1995.

**FOR FURTHER INFORMATION CONTACT:** Robert Wardwell, (410) 966-5659.

**SUPPLEMENTARY INFORMATION:**

**I. General Background**

Title XIX of the Social Security Act (the Act) authorizes States to establish Medicaid programs to provide medical assistance to needy individuals. Section 1902(a)(10) of the Act describes the two broad classifications of most individuals to whom medical assistance may be provided: The categorically needy (section 1902(a)(10)(A)) and the medically needy (section 1902(a)(10)(C)). Section 1905 of the Act defines medical assistance for purposes of the Medicaid program and specifies the services that constitute medical assistance.

Section 6405 of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Public Law 101-239, enacted on December 19, 1989, redesignated section 1905(a)(21) as section 1905(a)(22) and added a new section 1905(a)(21) to the Act to include services furnished by certified pediatric nurse practitioners (CPNPs) and by certified family nurse practitioners (CFNPs) in the definition of "medical assistance." Section 1905(a)(21) describes the added services as those that a nurse practitioner is legally authorized to perform under State law, whether or not the nurse

practitioner is under the supervision of, or associated with, a physician or other health care provider.

In addition, section 6405 of OBRA '89 amended section 1902(a)(10)(A) to include the nurse practitioner services listed in section 1905(a)(21) of the Act as services that must be made available to categorically needy recipients. Nurse practitioner services can be provided to medically needy recipients at the option of the State Medicaid agency.

Program instructions to help States implement the provisions of section 6405 of OBRA '89 were initially published in the State Medicaid Manual, Part 4, Services, in August 1990 (Transmittal Number 48). As a result, since July 1, 1990, States have been required to provide for direct payment to nurse practitioners for their services if the services are not billed by an employing provider (for example, a hospital clinic). These instructions included an administratively imposed requirement that CPNPs and CFNPs must be certified by national accrediting bodies.

**II. Notice of Proposed Rulemaking**

On December 23, 1991, we published in the **Federal Register** (56 FR 66392) a proposed rule to include in the Medicaid regulations coverage of and payment for services furnished by CPNPs and CFNPs, as provided by section 6405 of OBRA '89.

The proposed rule included revisions to 42 CFR parts 440 and 441 to define nurse practitioner services for purposes of this benefit, to set out the requirements for CPNPs and CFNPs, and to describe the permissible methods of payment for services. Under proposed § 440.166(a), we defined nurse practitioner services as services furnished within the scope of practice authorized by State law or regulations, by a practitioner who meets the requirements for a CPNP or a CFNP, regardless of whether the nurse practitioner is under the supervision of, or associated with, a physician or other health care provider.

In § 440.166(b), we proposed that a CPNP must—

- Be a registered professional nurse;
- Be currently licensed to practice in the State as a registered professional nurse;
- Meet the State requirements for qualification of pediatric nurse practitioners or nurse practitioners in the State in which he or she furnishes the services; and
- Be currently engaged in a pediatric nurse practice within the scope of applicable State law.

<sup>1</sup> Review for entitlement to special monthly compensation under § 3.350 of this chapter. [FR Doc. 95-9714 Filed 4-20-95; 8:45 am] BILLING CODE 8320-01-P

We proposed in § 440.166(c) that a CFNP must—

- Be a registered professional nurse;
- Be currently licensed to practice in the State as a registered professional nurse;
- Meet the State requirements for qualification of family nurse practitioners or nurse practitioners in the State in which he or she furnishes the services; and
- Be currently engaged in a family nurse practice within the scope of applicable State law.

We did not include in the proposed regulations the national certification requirement for CPNPs and CFNPs that we issued in the State Medicaid Manual, Part 4, Services, in August 1990. We eliminated this requirement to allow States the opportunity to use criteria other than national certification to qualify individuals as nurse practitioners in specialties.

In § 440.166(d), we proposed to require State Medicaid agencies to pay nurse practitioners directly under an independent provider agreement with the State Medicaid agency or, at the option of the nurse practitioner, through an employing provider. We proposed a new § 441.22(c) to require that State plans provide nurse practitioners with these payment options.

We proposed to revise § 440.210 and to add a new § 441.22(a) to require that nurse practitioner services described in § 440.166 be furnished to categorically needy recipients. We also proposed a new § 441.22(b) to require that a State plan specify whether the State is electing the option to furnish nurse practitioner services to the medically needy.

We proposed a new § 440.225 to specify that any service not required to be provided either to the categorically needy or to the medically needy may be furnished under a State plan at the State's option.

We also proposed some technical changes.

### III. Summary of Public Comments on the Proposed Rule and Departmental Responses

We received 28 timely pieces of correspondence that commented on the December 23, 1991, proposed rule. The comments came from State Medicaid agencies, medical centers, hospitals, consultant groups, nurse practitioners and associations of nurse practitioners, nurses, and medical directors. A summary of these public comments and our responses follow.

#### A. Requirements for CPNPs and CFNPs

*Comment:* Several commenters addressed our omission of the requirement that we had included in the State Medicaid Manual stipulating that CPNPs or CFNPs be certified by one of two specific national accrediting organizations. Two commenters indicated that we should have included the requirement in the proposed regulations, stating that the omission will result in less consistent quality of care and a less credible national standard. Three commenters supported our decision to omit the requirement, stressing the importance of allowing States flexibility to base qualifications on existing State certification mechanisms. These commenters stressed that this flexibility will result in additional qualified nurse practitioners.

*Response:* We intentionally did not incorporate the requirement included in the manual instructions that nurse practitioners be certified by national accrediting organizations into the proposed regulations. We omitted this requirement to avoid excluding from coverage nurse practitioners in several States that have detailed requirements for nurse practitioners that do not include use of national certification. This exclusion would be contrary to the statute's intent to provide maximum access to nurse practitioner services. Consequently, we are not making any change to the proposed § 440.166 to include the requirement that CPNPs or CFNPs be certified by national accrediting organizations. In the final rule, we are allowing States to determine their own requirements for pediatric and family nurse practitioners. In this way, by State law, a State can establish its own standards for these nurse practitioner specialties. For example, a State may specify its own requirements for training of pediatric or family nurse practitioners or, if it chooses, a State may require that nurse practitioners be certified by a national certification board.

*Comment:* Two commenters requested that we change the provision in the proposed rule that CPNPs and CFNPs must "meet the State requirements for qualification of pediatric or family nurse practitioners or nurse practitioners" to CPNPs and CFNPs must "meet the State requirements for nurses in advanced practice or nurse practitioners." The commenters pointed out that, in many States, State laws do not name nurse practitioners according to specialty; that is, pediatric or family practice, and instead refer to "nurses in advanced practice." In addition, both commenters

suggested that we require the nurses to be certified by a national certification board in pediatrics or family practice. One of these commenters also suggested that we define nurses in advanced practice as those who are authorized under State law to furnish those services stipulated by the State Board of Nursing and that we leave the definition of pediatric and family practice up to the State.

*Response:* The language used in the proposed rule provides parameters for practitioners in States that do not have specific requirements for pediatric or family nurse practitioners. In these States, the practitioner must have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age, or a family nurse practice limited to providing primary health care to individuals and families.

We did not intend to exclude from participation pediatric nurse practitioners or family nurse practitioners in any State where State law does not specifically name nurse practitioners according to specialty. We agree with commenters that those States that do not specifically define the specialties may instead define nurses in "advanced practice" or "nurse practitioners." Generally this means that the nurse has met advanced practice requirements beyond the 2 to 4 years of basic nursing education required of all registered nurses. In these States, therefore, registered nurses must meet the State requirements for nurses in "advance practice" or general nurse practitioners and must have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age, or a family nurse practice limited to providing primary health care to individuals and families. We have, therefore, revised § 440.166 (b)(2) and (c)(2) and included reference to nurses in advanced practice. Nurses in advanced practice or general nurse practitioners who wish to have their services covered under this benefit must be practicing as pediatric or family nurse practitioners within broad Federal definitions established in these regulations.

We encourage States to establish requirements for pediatric and family nurse practitioners and to define the scope of their practices. A State may require that nurse practitioners be certified by a national certification board as a pediatric or family nurse practitioner, or a State, itself, may define the scope of services that constitute pediatric or family nurse practitioner services. The Federal definitions will apply in those States

that have not established their own definitions.

*Comment:* One commenter disagreed with the requirement that CPNPs and CFNPs be currently engaged in a pediatric or family nurse practice, contending that this requirement could bar access to services; for example, by excluding new practitioners.

*Response:* We agree that the requirements that all nurse practitioners meet the State requirements for pediatric and family nurse practitioners and be currently engaged in a pediatric or family nurse practice could reduce the provider base of nurse practitioners. Consequently, we have revised the final regulations at § 440.166 (b) and (c) to require that licensed registered nurses in States that have specific requirements for pediatric and family nurse practitioners will need only to meet those State requirements. In States that do not have specific requirements for pediatric or family nurse practitioners, nurses in advanced practice and nurse practitioners may qualify by being engaged in a pediatric or family nurse practice within the scope of the Federal definitions. Thus, being currently engaged in a pediatric or family nurse practice will be one way that an individual can qualify as a provider of these services, but it will not be the only way an individual can qualify.

*Comment:* One commenter requested that we specify that the State requirements that CPNPs and CFNPs must meet are State requirements "as specified by the State Board of Nursing", since, according to this commenter, it is the State entity that interprets laws and regulations on the scope of practice for nurses. This commenter also suggested that the nurses in advanced practice be defined as those who are authorized under State law to furnish those services stipulated by the State Board of Nursing, and leave the definition of pediatric and family practice up to the States.

*Response:* While a State Board of Nursing may be the State entity legally responsible for defining the scope of practice for nurse practitioners in most States, we believe it is not feasible to specify the particular State governmental entity in Federal regulations, since the requirements in the regulations must apply to all States.

*Comment:* A large number of commenters requested that nurse practitioners with distinct specialties be included in coverage under this regulation. Four commenters supported the inclusion of nurse practitioners who specialize in providing family planning, gynecological, and prenatal care services, including obstetrics-

gynecology nurse practitioners, reproductive health nurse practitioners, and women's health nurse practitioners. Four commenters requested the inclusion of adult nurse practitioners—pointing out that these practitioners often provide access to care for adolescents and economically disadvantaged adults. Three commenters recommended covering the services of geriatric nurse practitioners. Four commenters noted that the inclusion of psychiatric clinical nurse specialists would provide important services for the mentally ill, reduce inappropriate care, and be unlikely to increase costs. One commenter asked for a clarification on whether other groups of nurse practitioners are included.

*Response:* Under the final regulations (§ 440.166 (b)(1) and (c)(1)), States will be able to define the scope of pediatric and family nurse practitioner services. The final rule specifies only that in States that have not established requirements for pediatric or family nurse practitioners or defined the scope of their practice, (1) pediatric nurse practitioners have a practice limited to providing primary health care to persons less than 21 years of age, and (2) family nurse practitioners have a practice limited to providing primary health care to individuals and families. These Federal definitions will apply only in States that have not established their own requirements or definitions. In these States, the State will decide if the practitioner's specialty fits within the broad Federal definitions and apply the regulations accordingly. The services performed by many of the specific nurse practitioners cited by the commenters may be covered under the nurse practitioner benefit if they fall under the broad Federal definition. Many of these specific nurse practitioner services could also be covered, at a State's option, under the Medicaid benefit of medical or other remedial care provided by licensed practitioners as specified in § 440.60.

*Comment:* One commenter requested that the requirements for family nurse practitioners who provide services to nursing facility residents include geriatric and drug therapy training.

*Response:* While we do not challenge the value of such training for CFNPs, we believe it is inappropriate for these regulations to specify requirements at this level of detail. A State may choose to address the need for this specific training in the requirements it establishes for certification of CFNPs.

### B. Classification of Nurse Practitioner Services

*Comment:* One commenter opposed any provision of services in nursing facilities that are not under the direction of a physician, and raised concerns about nurse practitioners practicing independently in those settings. Another commenter asked for clarification on whether direct payment to nurse practitioners can be offered in any setting.

*Response:* These concerns raise some very complex Medicaid coverage issues. To help clarify the payment process for nurse practitioners, we are starting this response with some general information on how all Medicaid services are paid. We are following this with some more specific information on nurse practitioner services.

Generally, Medicaid services are classified by categories. Each separate category may have specific Federal requirements relating to supervision or location of services. Some services, such as inpatient hospital, nursing facility, and clinic services, are described in terms of their setting. Other services, such as rehabilitation or physical therapy, are described by the type of service being furnished. Finally, some services, such as nurse practitioner and physician services, are described in terms of the individual providing services. Each category is separate and has a distinct set of requirements.

While we view each category of services as separate, some services, including nurse practitioner services, can be classified in more than one category. However, the specific circumstances under which a service is provided will determine which category the provider should use when submitting a claim. It is possible that a specific claim could meet the requirements under one category and not another even though, as a general rule, the service could be submitted under either category.

When a provider submits a claim for payment, the provider must identify the service by using a procedure code. The claim is reviewed to assure that it meets the requirements for payment. This review is based on the information provided on the claim submission. Therefore, any service that is submitted for Medicaid payment must meet the requirements of the procedure code that the provider designates on a claim for payment. Consequently, the provider must use care when submitting a claim to avoid having the claim rejected because it does not meet the requirements of the designated category. The claim must meet those

requirements to be eligible for payment; otherwise, it will be rejected. (A rejected claim could be resubmitted under the proper category.)

The category of nurse practitioner services has certain similarities to physician services that should help clarify how nurse practitioner services are classified under Medicaid.

First, like physician services, nurse practitioner services are limited in scope only through State licensure or scope of practice laws.

Second, at the Federal level, there are no restrictions on where either physician or nurse practitioner services are furnished.

Third, the Medicaid statute does not dictate that a physician who practices in a hospital or clinic must receive payment through the hospital or clinic. This same type of flexibility extends to nurse practitioners.

Fourth, while services provided by physicians or nurse practitioners can each be classified in its distinct category, both services can also be billed in other categories such as outpatient hospital and clinic services.

As an example of how the billing category governs the classification of nurse practitioner services, we can compare two methods of billing for nurse practitioner services performed in a clinic setting. If the clinic bills the program for the nurse practitioner services, the services will be considered to be clinic services and all Federal requirements relating to clinics must be met. That is, the service provided by a nurse practitioner in the clinic setting must be provided under the overall direction of a physician. If, instead, a nurse practitioner bills for the services as nurse practitioner services (which happen to be furnished in a clinic setting), supervision is irrelevant.

Generally, to be acceptable for direct payment, billing for nurse practitioner services provided in any setting must be submitted under the category of nurse practitioner services. A nurse practitioner furnishing services in a hospital or clinic should not bill Medicaid for direct payment under the categories of hospital or clinic services because the nurse practitioner would not be able to meet the criteria for payment under these categories, for example, the conditions of participation applicable to hospitals.

The issue of the setting of the services also has an impact on both the supervision of services and the billing for services. If a nurse practitioner furnishes services in a hospital or a clinic and bills Medicaid independently under the Medicaid service category of nurse practitioner services, the issue of

supervision is generally irrelevant for purposes of Medicaid coverage. The issue of supervision is more complex for nurse practitioner services performed in nursing facilities and rural health clinics. However, for reasons discussed below, we will also allow direct billing for nurse practitioner services performed in these latter settings.

As mentioned by a commenter, section 1919(b)(6) of the Act requires that the health care of every resident of a nursing facility be provided under the supervision of a physician (or at State option, under the supervision of a nurse practitioner who is not an employee of the facility but is working in collaboration with a physician). When providing services in a nursing facility, a nurse practitioner must either be under the supervision of, or have an association with, a physician.

Services furnished in rural health clinics, as defined at section 1905(1) of the Act (which refers to section 1861(aa) of the Act), similarly require supervision of a nurse practitioner by a physician.

Because supervision is required under sections 1919(b)(6) and 1905(1), these sections appear to prohibit any nurse practitioner that works in a nursing facility or rural health clinic from directly billing Medicaid for services. We believe it would be contrary to the Congressional intent of section 1905(a)(2) of the Act to prohibit a nurse practitioner working in either of these settings from billing for direct payment for nurse practitioner services. Consequently, we are allowing a nurse practitioner to bill directly for nurse practitioner services furnished in a nursing facility or rural health clinic even though the services must be furnished under the supervision of, or in association with, a physician.

Because nurse practitioner services can now be billed either directly or indirectly, we recognize that there is some potential for duplicate billing. However, we anticipate that nurse practitioners will enter into billing agreements with other health care providers, for example, clinics. We expect that these agreements will specify which entity will bill the Medicaid program for the services and how a nurse practitioner will be paid—either directly by the Medicaid program or indirectly through the other health care provider. In addition, the respective provider agreements with a State Medicaid agency may also include provisions which ensure that duplicate payments are not made. The State, however, may not require a nurse practitioner to be associated with or bill through another health care provider.

### C. Physician Referral and Supervision Issues

*Comment:* One commenter requested that HCFA amend the regulation regarding long-term care facilities (§ 483.40) to allow a physician to delegate tasks to a nurse practitioner only if the nurse practitioner is not an employee of the facility.

*Response:* This suggested revision has already been published under § 483.40 (56 FR 48875, September 26, 1991) effective April 1, 1992.

*Comment:* One commenter requested that we amend the regulation at § 440.110 that requires that physical therapy and occupational therapy be prescribed by a physician, and that speech, hearing, and language services be referred by a physician. The commenter pointed out that the proposed rule defines nurse practitioner services as services that the CPNP or CFNP is legally authorized to perform under State law, and that, in the commenter's State, nurse practitioners are legally authorized to order these therapy services for recipients. The commenter stated that an amendment that allowed nurse practitioners to prescribe or refer patients for these therapy services would further the statutory intent of ensuring that Medicaid payment is available for these services. The commenter noted that Federal regulations for a number of other services allow the services to be recommended by a physician or other licensed practitioner.

*Response:* We agree that the regulation, as written, requiring physician prescription or referral for the therapy services creates a barrier to allowing nurse practitioners to provide services that they are authorized to provide under State law in some States. This was not our intent. Consequently, we are expanding § 440.110 to permit a licensed practitioner of the healing arts, within the scope of his or her practice under State law, to prescribe or refer these therapy services for recipients. This revision enables nurse practitioners to refer recipients to physical therapy, occupational therapy, speech services and language services when allowed under State law.

### D. Payment Options for Nurse Practitioner Services

*Comment:* One State agency disagreed with the proposed rule that requires States to permit nurse practitioners to be paid through employing providers. This State pays nurse practitioners directly through independent provider agreements. The commenter contended that this method allows the State to

avoid duplicate billing and verify licensing requirements. The commenter asserted that the change will create claims, reporting, and systems problems.

*Response:* The intent of the statute clearly is to provide maximum access to certain nurse practitioner services by providing alternative modes of payment. Payment for such services may be made either directly to a nurse practitioner or indirectly through an employing provider. Direct payment may be made to a nurse practitioner who is a participating Medicaid provider without regard to whether he or she practices independently or works under the supervision of, or in association with, health care providers. Indirect payment may be made when a nurse practitioner is paid through an employing provider and does not bill Medicaid. For example, if the nurse practitioner is an employee of a hospital or a clinic, the hospital or clinic may pay the nurse practitioner and bill Medicaid for hospital or clinic services. The State will need to establish administrative arrangements to avoid duplicate payments. While we realize that this places some administrative burden on States, we believe it is clearly the intent of the statute to allow nurse practitioners to participate in the Medicaid program and bill for services when appropriate (that is, if the services are not paid by an employing provider such as a hospital or clinic).

*Comment:* In one State, according to a commenter, nurse practitioners are limited by State law to providing routine nursing care. The commenter opposed the direct payment to a nurse practitioner for these services, and questioned whether the regulation intends to mandate direct payment to a nurse practitioner who provides this limited scope of services. The commenter indicated a willingness to propose a change in State law to allow nurse practitioners to provide advanced services, but must first determine the services that the nurse practitioners could perform that would qualify for payment.

*Response:* The statute states that the nurse practitioner services that are to be covered are those which a nurse practitioner is legally authorized to perform under State law. We believe the statute does not give us authority to override State nurse practice rules. Hence, any service that a nurse practitioner is authorized to perform under State law, such as the routine nursing care the commenter described, must be covered as nurse practitioner services. As the commenter pointed out, States can choose to expand or restrict

the services that nurse practitioners are legally authorized to perform in the State by changing State laws or regulations defining nurse practitioner services.

*Comment:* Two commenters recommended changes that would clarify that States are required to allow a nurse practitioner to be paid either through an employing provider or through an independent provider agreement, whether or not the nurse practitioner is under the supervision of, or associated with, a physician or other health care provider. One commenter asked that we clarify the language in § 440.166(d) that the Medicaid agency "may pay" for nurse practitioner services, and the other commenter suggested that we clarify the wording in § 441.22(c).

*Response:* The intent of the regulations on payment is to emphasize that States are required to allow a nurse practitioner the option of being paid either through an independent provider agreement as a Medicaid participating provider or through an employing provider when the employing provider bills Medicaid. We have clarified § 441.22(c) to explain a nurse practitioner may be paid through either method whether he or she is under the supervision of, or associated with, a physician or other health care provider.

#### *E. Other Issues*

*Comment:* One commenter disagrees with the decision to make nurse practitioner services optional for the medically needy. The commenter pointed out that nurse midwife services are mandated for the medically needy under the section of the regulations that describes the required services for the medically needy (§ 440.220), and stated that the Congress intended to include nurse practitioner services in this section.

*Response:* We do not agree that the Congress intended to mandate nurse practitioner services for the medically needy. Moreover, § 440.220 simply reiterates the options in the statute and does not mandate nurse midwife services for the medically needy. Under section 1902(a)(10)(C) (iii) and (iv) of the Act, if a State chooses to provide services to any medically needy group in institutions for mental diseases or intermediate care facilities for the mentally retarded, or both, the State must include for all medically needy groups at least the services listed in section 1905(a) (1) through (5) and (17) (nurse midwife services) or any seven services under section 1905(a) (1) through (21). A State may choose to *not* cover nurse midwife services for the

medically needy by choosing seven other services. We have retained the proposed § 440.225 to clarify that any service that is not mandated for the categorically needy or medically needy may be furnished under a State plan at the State's option.

#### **IV. Provisions of the Final Rule**

We are adopting the proposed regulations as final regulations with the following revisions:

- We have revised § 440.110 to include provisions that allow a licensed practitioner of the healing arts, within the scope of his or her practice under State law, to prescribe physical and occupational therapy services for recipients and to refer recipients for other therapy services.
- We have revised the proposed § 440.166(a) to describe nurse practitioner services as services that are furnished by a registered professional nurse who meets a State's advanced educational and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses.
- We have revised the proposed § 440.166 (b) and (c) to include the requirements that nurses in advanced practice must meet to qualify as CFNPs and CPNPs. Licensed registered nurses in States that have specific requirements for pediatric and family nurse practitioners will need only to meet those State requirements. In States that do not have specific requirements for pediatric or family nurse practitioners, nurses in advanced practice and general nurse practitioners may qualify by being engaged in a pediatric or family nurse practice within the scope of the State's definitions or within Federal definitions.
- We have revised the proposed § 441.22(c) to clarify that a nurse practitioner has the option of being paid either through an independent provider agreement or through an employing provider regardless of whether he or she is under the supervision of, or associated with, a physician or other health care provider.

#### **V. Regulatory Impact Statement**

We generally prepare a regulatory impact analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless the Secretary certifies that a final regulation will not have a significant economic impact on a substantial number of small entities. For purposes of RFA, physicians and all nurse practitioners who work on a consulting basis or who are self-employed are considered to be small entities.

Also, section 1102(b) of the Act requires the Secretary to prepare a regulatory impact analysis if a final rule may have an impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we consider a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and that has fewer than 50 beds.

This final rule adopts the December 23, 1991, proposed rule with modifications, based on comments submitted by the public. A summary of the public comments and the departmental responses are included in part II above. In the proposal, we included an impact analysis (57 FR 66394) that indicated that the impact was negligible. None of the responses to our request for public comment addressed our proposed impact analysis. In addition, we believe that none of the changes incorporated into the final rule require any revision to our statement in the proposal that the impact was negligible. Consequently, we continue to believe that the impact of this final rule is negligible. We are, therefore, not preparing a regulatory impact analysis for this final rule.

We have determined, and the Secretary certifies, that these final regulations will not have significant economic impact on a substantial number of small entities and will not have a significant impact on the operations of a substantial number of small rural hospitals. Therefore, we have not prepared a regulatory flexibility analysis or an analysis of effects on small rural hospitals.

In accordance with the provisions of Executive Order 12866, this final regulation was reviewed by the Office of Management and Budget.

## VI. Paperwork Burden

Section 441.22 of this final rule contains information collection requirements that are subject to Office of Management and Budget (OMB) approval under the Paperwork Reduction Act of 1980 (44 U.S.C. Chapter 35). Under these final regulations, a State will be required to specify in its State Medicaid plan that it provides nurse practitioner services to the categorically needy. A State must also specify whether or not it furnishes nurse practitioner services to the medically needy. In addition, a State must provide that services furnished by a nurse practitioner, regardless of whether the nurse practitioner is under the supervision of, or associated with, a

physician or other health care provider, may be paid by the State Medicaid agency through an independent provider agreement between the State and the nurse practitioner; or be paid through the employing provider. The public reporting burden for this collection of information is estimated to be a half hour per response. A notice will be published in the **Federal Register** when OMB approval is received.

### List of Subjects

#### 42 CFR Part 440

Grant programs—health, Medicaid.

#### 42 CFR Part 441

Family planning, Grant programs—health, Infants and children, Medicaid, Penalties, Prescription drugs, Reporting and recordkeeping requirements.

42 CFR Chapter IV is amended as follows:

### PART 440—SERVICES: GENERAL PROVISIONS

A. Part 440 is amended as follows:

1. The authority citation for part 440 continues to read as follows:

**Authority:** Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. In § 440.110, paragraphs (a)(1), (b)(1), and (c)(1), are revised to read as follows:

#### § 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(a) *Physical therapy.* (1) *Physical therapy* means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment.

\* \* \* \* \*

(b) *Occupational therapy.* (1) *Occupational therapy* means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.

\* \* \* \* \*

(c) *Services for individuals with speech, hearing, and language disorders.* (1) *Services for individuals with speech, hearing, and language disorders* means diagnostic, screening, preventive, or corrective services provided by or under the direction of a

speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment.

\* \* \* \* \*

3. A new § 440.166 is added to read as follows:

#### § 440.166 Nurse practitioner services.

(a) *Definition of nurse practitioner services.* Nurse practitioner services means services that are furnished by a registered professional nurse who meets a State's advanced educational and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses.

(b) *Requirements for certified pediatric nurse practitioner.* The practitioner must be a registered professional nurse who meets the requirements specified in either paragraphs (b)(1) or (b)(2) of this section.

(1) If the State specifies qualifications for pediatric nurse practitioners, the practitioner must—

(i) Be currently licensed to practice in the State as a registered professional nurse; and

(ii) Meet the State requirements for qualification of pediatric nurse practitioners in the State in which he or she furnishes the services.

(2) If the State does not specify, by specialty, qualifications for pediatric nurse practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must—

(i) Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and

(ii) Have a pediatric nurse practice limited to providing primary health care to persons less than 21 years of age.

(c) *Requirements for certified family nurse practitioner.* The practitioner must be a registered professional nurse who meets the requirements specified in either paragraph (c)(1) or (c)(2) of this section.

(1) If the State specifies qualifications for family nurse practitioners, the practitioner must—

(i) Be currently licensed to practice in the State as a registered professional nurse; and

(ii) Meet the State requirements for qualification of family nurse practitioners in the State in which he or she furnishes the services.

(2) If the State does not specify, by specialty, qualifications for family nurse

practitioners, but the State does define qualifications for nurses in advanced practice or general nurse practitioners, the practitioner must—

(i) Meet qualifications for nurses in advanced practice or general nurse practitioners as defined by the State; and

(ii) Have a family nurse practice limited to providing primary health care to individuals and families.

(d) *Payment for nurse practitioner services.* The Medicaid agency must reimburse nurse practitioners for their services in accordance with § 441.22(c) of this subchapter.

4. In § 440.210, the introductory text of paragraph (a) and paragraph (a)(1) are revised to read as follows:

**§ 440.210 Required services for the categorically needy.**

(a) A State plan must specify that, at a minimum, categorically needy recipients are furnished the following services:

(1) The services defined in §§ 440.10 through 440.50, 440.70, and (to the extent nurse-midwives and nurse practitioners are authorized to practice under State law or regulation) the services defined in §§ 440.165 and 440.166, respectively.

\* \* \* \* \*

5. A new § 440.225 is added to read as follows:

**§ 440.225 Optional services.**

Any of the services defined in subpart A of this part that are not required under §§ 440.210 and 440.220 may be furnished under the State plan at the State's option.

B. Part 441 is amended as follows:

**PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES**

1. The authority citation for part 441 continues to read as follows:

**Authority:** Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 441.10 is revised to read as follows:

**§ 441.10 Basis.**

This subpart is based on the following sections of the Act which state requirements and limits on the services specified or provide Secretarial authority to prescribe regulations relating to services:

(a) Section 1102 for end-stage renal disease (§ 441.40).

(b) Section 1138(b) for organ procurement organization services (§ 441.13(c)).

(c) Sections 1902(a)(10)(A) and 1905(a)(21) for nurse practitioner services (§ 441.22).

(d) Sections 1902(a)(10)(D) and 1905(a)(7) for home health services (§ 441.15).

(e) Section 1903(i)(1) for organ transplant procedures (§ 441.35).

(f) Section 1903(i)(5) for certain prescribed drugs (§ 441.25).

(g) Section 1903(i)(6) for prohibition (except in emergency situations) of FFP in expenditures for inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner (§ 441.12).

(h) Section 1905(a)(4)(C) for family planning (§ 441.20).

(i) Sections 1905 (a)(12) and (e) for optometric services (§ 441.30).

(j) Section 1905(a)(17) for nurse-midwife services (§ 441.21).

(k) Section 1905(a) (following (a)(24)) for prohibition of FFP in expenditures for certain services (§ 441.13).

3. A new § 441.22 is added to read as follows:

**§ 441.22 Nurse practitioner services.**

With respect to nurse practitioner services that meet the definition of § 440.166(a) and the requirements of either § 440.166(b) or § 440.166(c), the State plan must meet the following requirements:

(a) Provide that nurse practitioner services are furnished to the categorically needy.

(b) Specify whether those services are furnished to the medically needy.

(c) Provide that services furnished by a nurse practitioner, regardless of whether the nurse practitioner is under the supervision of, or associated with, a physician or other health care provider, may—

(1) Be reimbursed by the State Medicaid agency through an independent provider agreement between the State and the nurse practitioner; or

(2) Be paid through the employing provider.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: August 30, 1994.

**Bruce C. Vladeck,**  
*Administrator, Health Care Financing Administration.*

Dated: January 24, 1995.

**Donna E. Shalala,**  
*Secretary.*

[FR Doc. 95-9954 Filed 4-20-95; 8:45 am]

BILLING CODE 4120-01-P

**Administration for Children and Families**

**45 CFR Part 212**

RIN 0970-AB45

**Assistance for United States Citizens Returned From Foreign Countries**

**AGENCY:** Administration for Children and Families, HHS, Office of Refugee Resettlement.

**ACTION:** Final rule.

**SUMMARY:** This rule amends the regulations for the U.S. Repatriate Program. Under the U.S. Repatriate Program, State agencies provide assistance to groups of United States citizens who are returned from foreign countries to the United States by the Department of State due to war, threat of war, civil disorder, or natural disaster. This rule requires such agencies to request and obtain advance approval from the Administration for Children and Families (ACF) to incur expenses for developing and preparing to implement repatriation plans for groups of eligible persons. This rule is necessary in order for ACF to provide appropriate oversight of the limited funding available for such activities.

**EFFECTIVE DATE:** This rule is effective May 22, 1995.

**FOR FURTHER INFORMATION CONTACT:** David B. Smith, Director, Division of State Legalization and Repatriation, Office of Refugee Resettlement, Administration for Children and Families, 370 L'Enfant Promenade, SW., 6th floor, Washington, DC 20447. Telephone: 202-401-9255.

**SUPPLEMENTARY INFORMATION:**

**Background**

The U.S. Repatriate Program is authorized by Section 1113 of the Social Security Act and is responsive to Executive Order 12656 regarding services provided to repatriated U.S. citizens. The program provides temporary assistance through State agencies to needy U.S. citizens and their dependents who are returned to the United States by the Department of State for reasons of destitution, illness, war, threat of war, invasion, civil unrest, or natural disaster in a foreign country. Under current law and regulations, assistance provided through the program to repatriates must be repaid to the United States Government unless the Administration for Children and Families specifically waives this requirement.