

42 CFR Subpart D 441.150-441.182

Subpart D—Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs

§441.150 Basis and purpose.

This subpart specifies requirements applicable if a State provides inpatient psychiatric services to individuals under age 21, as defined in §440.160 of this subchapter and authorized under section 1905 (a)(16) and (h) of the Act.

§441.151 General requirements.

(a) Inpatient psychiatric services for individuals under age 21 must be:

(1) Provided under the direction of a physician;

(2) Provided by—

(i) A psychiatric hospital that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital as specified in §482.60 of this chapter, or is accredited by a national organization whose psychiatric hospital accrediting program has been approved by CMS; or a hospital with an inpatient psychiatric program that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital, as specified in part 482 of this chapter, or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS.

(ii) A psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards that is recognized by the State.

(3) Provided before the individual reaches age 21, or, if the individual was receiving the services immediately before he or she reached age 21, before the earlier of the following—

(i) The date the individual no longer requires the services; or

(ii) The date the individual reaches 22; and

(4) Certified in writing to be necessary in the setting in which the services will be provided (or are being provided in emergency circumstances) in accordance with §441.152.

(b) Inpatient psychiatric services furnished in a psychiatric residential treatment facility as defined in §483.352 of this chapter, must satisfy all requirements in subpart G of part 483 of this chapter governing the use of restraint and seclusion.

§441.152 Certification of need for services.

(a) A team specified in §441.154 must certify that—

(1) Ambulatory care resources available in the community do not meet the treatment needs of the beneficiary;

(2) Proper treatment of the beneficiary's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(3) The services can reasonably be expected to improve the beneficiary's condition or prevent further regression so that the services will no longer be needed.

(b) The certification specified in this section and in §441.153 satisfies the utilization control requirement for physician certification in §§456.60, 456.160, and 456.360 of this subchapter.

[43 FR 45229, Sept. 29, 1978, as amended at 61 FR 38398, July 24, 1996]

§441.153 Team certifying need for services.

Certification under §441.152 must be made by terms specified as follows:

(a) For an individual who is a beneficiary when admitted to a facility or program, certification must be made by an independent team that—

(1) Includes a physician;

(2) Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and

(3) Has knowledge of the individual's situation.

(b) For an individual who applies for Medicaid while in the facility of program, the certification must be—

(1) Made by the team responsible for the plan of care as specified in §441.156; and

(2) Cover any period before application for which claims are made.

(c) For emergency admissions, the certification must be made by the team responsible for the plan of care (§441.156) within 14 days after admission.

§441.154 Active treatment.

Inpatient psychiatric services must involve "active treatment", which means implementation of a professionally developed and supervised individual plan of care, described in §441.155 that is—

(a) Developed and implemented no later than 14 days after admission; and

(b) Designed to achieve the beneficiary's discharge from inpatient status at the earliest possible time.

§441.155 Individual plan of care.

(a) "Individual plan of care" means a written plan developed for each beneficiary in accordance with §§456.180 and 456.181 of this chapter, to improve his condition to the extent that inpatient care is no longer necessary.

(b) The plan of care must—

- (1) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the beneficiary's situation and reflects the need for inpatient psychiatric care;
- (2) Be developed by a team of professionals specified under §441.156 in consultation with the beneficiary; and his parents, legal guardians, or others in whose care he will be released after discharge;
- (3) State treatment objectives;
- (4) Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and
- (5) Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the beneficiary's family, school, and community upon discharge.

(c) The plan must be reviewed every 30 days by the team specified in §441.156 to—

- (1) Determine that services being provided are or were required on an inpatient basis, and
- (2) Recommend changes in the plan as indicated by the beneficiary's overall adjustment as an inpatient.

(d) The development and review of the plan of care as specified in this section satisfies the utilization control requirements for—

- (1) Recertification under §§456.60(b), 456.160(b), and 456.360(b) of this subchapter; and
- (2) Establishment and periodic review of the plan of care under §§456.80, 456.180, and 456.380 of this subchapter.

[43 FR 45229, Sept. 29, 1978, as amended at 46 FR 48560, Oct. 1, 1981; 61 FR 38398, July 24, 1996]

§441.156 Team developing individual plan of care.

(a) The individual plan of care under §441.155 must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in, the facility.

(b) Based on education and experience, preferably including competence in child psychiatry, the team must be capable of—

(1) Assessing the beneficiary's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

(2) Assessing the potential resources of the beneficiary's family;

(3) Setting treatment objectives; and

(4) Prescribing therapeutic modalities to achieve the plan's objectives.

(c) The team must include, as a minimum, either—

(1) A Board-eligible or Board-certified psychiatrist;

(2) A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

(3) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

(d) The team must also include one of the following:

(1) A psychiatric social worker.

(2) A registered nurse with specialized training or one year's experience in treating mentally ill individuals.

(3) An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals.

(4) A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

§441.180 Maintenance of effort: General rule.

FFP is available only if the State maintains fiscal effort as prescribed under this subpart.

§441.181 Maintenance of effort: Explanation of terms and requirements.

(a) For purposes of §441.182:

(1) The base year is the 4-quarter period ending December 31, 1971.

(2) Quarterly per capita non-Federal expenditures are expenditures for inpatient psychiatric services determined by reimbursement principles under Medicare. (See part 405, subpart D.)

(3) The number of individuals receiving inpatient psychiatric services in the current quarter means—

(i) The number of individuals receiving services for the full quarter; plus

(ii) The full quarter composite number of individuals receiving services for less than a full quarter.

(4) In determining the per capita expenditures for the base year, the Medicaid agency must compute the number of individuals receiving services in a manner similar to that in paragraph (a)(3) of this section.

(5) Non-Federal expenditures means the total amount of funds expended by the State and its political subdivisions, excluding Federal funds received directly or indirectly from any source.

(6) Expenditures for the current calendar quarter exclude Federal funds received directly or indirectly from any source.

(b) As a basis for determining the correct amount of Federal payments, each State must submit estimated and actual cost data and other information necessary for this purpose in the form and at the times specified in this subchapter and by CMS guidelines.

(c) The agency must have on file adequate records to substantiate compliance with the requirements of §441.182 and to ensure that all necessary adjustments have been made.

(d) Facilities that did not meet the requirements of §§441.151-441.156 in the base year, but are providing inpatient psychiatric services under those sections in the current quarter, must be included in the maintenance of effort computation if, during the base year, they were—

(1) Providing inpatient psychiatric services for individuals under age 21; and

(2) Receiving State aid.

§441.182 Maintenance of effort: Computation.

(a) For expenditures for inpatient psychiatric services for individuals under age 21, in any calendar quarter, FFP is available only to the extent that the total State Medicaid expenditures in the current quarter for inpatient psychiatric services and outpatient psychiatric treatment for individuals under age 21 exceed the sum of the following:

(1) The total number of individuals receiving inpatient psychiatric services in the current quarter times the average quarterly per capita non-Federal expenditures for the base year; and

(2) The average non-Federal quarterly expenditures for the base year for outpatient psychiatric services for individuals under age 21.

(b) FFP is available for 100 percent of the increase in expenditures over the base year period, but may not exceed the Federal medical assistance percentage times the expenditures under this subpart for inpatient psychiatric services for individuals under age 21.