DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 440 and 441

[CMS 2261-P]

RIN 0938-A081

Medicaid Program; Coverage for Rehabilitative Services

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would amend the definition of Medicaid rehabilitative services in order to provide for important beneficiary protections such as a person-centered written rehabilitation plan and maintenance of case records. The proposed rule would also ensure the fiscal integrity of claimed Medicaid expenditures by clarifying the service definition and providing that Medicaid rehabilitative services must be coordinated with but do not

include services furnished by other programs that are focused on social or educational development goals and available as part of other services or programs. These services and programs include, but are not limited to, foster care, child welfare, education, child care, prevocational and vocational services, housing, parole and probation, juvenile justice, public guardianship, and any other non-Medicaid services from Federal, State, or local programs.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on 60 days after date of publication in the **Federal Register**.

ADDRESSES: In commenting, please refer to file code CMS-2261-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. Electronically. You may submit electronic comments on specific issues in this regulation to http://www.cms.hhs.gov/eRulemaking. Click on the link "Submit electronic comments on CMS regulations with an open comment period." (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. By regular mail. You may mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-2261-P,

P.O. Box 8018,

Baltimore, MD 21244-8018.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-2261-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call

telephone number (410) 786-3685 in advance to schedule your arrival with one of our staff members.

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201; or

7500 Security Boulevard,

Baltimore, MD 21244-1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the "Collection of Information Requirements" section in this document.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Maria Reed, (410) 786-2255 or Shawn Terrell, (410) 786 0672.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS-2261-P and the specific "issue identifier" that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable (for example, names, addresses, social security numbers, and medical diagnoses) or confidential business information (including proprietary information) that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: http://www.cms.hhs.gov/eRulemaking. Click on the link "Electronic Comments on CMS Regulations" on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning

approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Background

A. Overview

Section 1905(a)(13) of the Social Security Act (the Act) includes rehabilitative services as an optional Medicaid State plan benefit. Current Medicaid regulations at 42 CFR 440.130(d) provide a broad definition of rehabilitative services. Rehabilitative services are defined as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." The broad general language in this regulatory definition has afforded States considerable flexibility under their State plans to meet the needs of their State's Medicaid population.

Over the years the scope of services States have provided under the rehabilitation benefit has expanded from

physical rehabilitative services to also include mental health and substance abuse treatment rehabilitative services. For example, services currently provided by States under the rehabilitative benefit include services aimed at improving physical disabilities, including physical, occupational, and speech therapies; mental health services, such as individual and group therapy, psychosocial therapy services; and services for substance-related disorders (for example, substance use disorders and substance induced disorders). These Medicaid services may be delivered through various models of care and in a variety of settings.

The broad language of the current statutory and regulatory definition has, however, had some unintended consequences. It has also led to some confusion over whether otherwise applicable statutory or regulatory provider standards would apply under the rehabilitative services benefit.

As the number of States providing rehabilitative services has increased, some States have viewed the rehabilitation benefit as a "catch-all" category to cover services included in other Federal, State and local programs. For example, it appears some States have used Medicaid to fund services that are included in the

provision of foster care and in the Individuals with Disabilities Education Improvement Act (IDEA). Our audit reviews have recently revealed that Medicaid funds have also been used to pay for behavioral treatment services in "wilderness camps," juvenile detention, and similar facilities where youth are involuntarily confined. These facilities are under the domain of the juvenile justice or youth systems in the State, rather than Medicaid, and there is no assurance that the claimed services reflect an independent evaluation of individual rehabilitative needs.

This proposed regulation is designed to clarify the broad general language of the current regulation to ensure that rehabilitative services are provided in a coordinated manner that is in the best interest of the individuals, are limited to rehabilitative purposes and are furnished by qualified providers. This proposed regulation would rectify the improper reliance on the Medicaid rehabilitation benefit for services furnished by other programs that are focused on social or educational development goals in programs other than Medicaid.

This proposed regulation would provide guidance to ensure that services claimed under the optional Medicaid rehabilitative benefit are in fact rehabilitative out-patient services, are furnished by qualified providers, are

provided to Medicaid eligible individuals according to a goal-oriented rehabilitation plan, and are not for services that are included in programs with a focus other than that of Medicaid.

B. Habilitation Services

Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) prohibits us from taking adverse action against States with approved habilitation provisions pending the issuance of a regulation that "specifies types of day habilitation services that a State may cover under paragraphs (9)(clinic services) or (13)(rehabilitative services) of section 1905(a) of the Act on behalf of persons with mental retardation or with related conditions." We believe that issuance of a final rule based on this proposed rule will satisfy this condition. We intend to work with those States that have habilitation programs under the clinic services or rehabilitative services benefits in their State plans to transition to appropriate Medicaid coverage authorities, such as section 1915(c) waivers or the Home and Community-Based Services State plan option under section 1915 (i) of the Deficit Reduction Act (DRA) of 2005, (Pub. L. 107-171) enacted on February 8, 2006.

II. Provisions of the Proposed Rule

[If you choose to comment on issues in this section, please include the caption "PROVISIONS OF THE PROPOSED REGULATIONS" at the beginning of your comments.]

A. Definitions

In 440.130(d)(1), we propose to define the terms used in this rule, as listed below:

- Recommended by a physician or other licensed practitioner of the healing arts.
- Other licensed practitioner of the healing arts.
- Qualified providers of rehabilitative services.
- Under the direction of.
- Written rehabilitation plan.
- Restorative services.
- Medical services.
- Remedial services.

In §440.130(d)(1)(iii), we would define "qualified providers of rehabilitative services" to require that individuals providing rehabilitative services meet the provider qualification requirements applicable to the same service when it is furnished under other benefit categories. Further, the provider qualifications must be set forth in the Medicaid State plan. These qualifications may include education, work experience, training,

credentialing, supervision and licensing, that are applied uniformly. Provider qualifications must be reasonable given the nature of the service provided and the population being served. We require uniform application of these qualifications to ensure the individual free choice of qualified providers, consistent with section 1902(a)(23) of the Act.

Under this proposed definition, if specific provider qualifications are set forth elsewhere in subpart A of part 440, those provider qualifications take precedence when those services are provided under the rehabilitation option. Thus, if a State chooses to provide the various therapies discussed at §440.110 (physical therapy, occupational therapy, speech, language and hearing services) under §440.130(d), the requirements of §440.110 applicable to those services would apply. For example, speech therapy is addressed in regulation at §440.110(c) with specific provider requirements for speech pathologists and audiologists that must be met. If a State offers speech therapy as a rehabilitative service, the specific provider requirements at §440.110(c) must be met. It should be noted that the definition of Occupational Therapy in §440.110 is not correct insofar as the following – Occupational Therapists must be certified through the

National Board of Certification for Occupational Therapy, not the American Occupational Therapy Association.

We are proposing a definition of the term "under the direction of" because it is a key issue in the provision of therapy services through the rehabilitative services benefit. Therapy services may be furnished by or "under the direction of" a qualified provider under the provisions of §440.110. We are proposing to clarify that the term means that the therapist providing direction is supervising the individual's care which, at a minimum, includes seeing the individual initially, prescribing the type of care to be provided, reviewing the need for continued services throughout treatment, assuming professional responsibility for services provided, and ensuring that all services are medically necessary. The term "under the direction of" requires each of these elements; in particular, professional responsibility requires face-to-face contact by the therapist at least at the beginning of treatment and periodically thereafter. Note that this definition applies specifically to providers of physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. This language is not meant to exclude appropriate supervision arrangements for other rehabilitative services.

B. Scope of Services

Consistent with the provision of section 1905(a)(13) of the Act, we have retained the current definition of rehabilitative services in §440.130(d)(2) as including "medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." We would, however, clarify that rehabilitative services do not include room and board in an institution, consistent with the longstanding CMS interpretation that section 1905(a) of the Act has specifically identified circumstances in which Medicaid would pay for coverage of room and board in an inpatient setting. This interpretation was upheld in ***Texas v. U.S. Dep't Health and Human Servs.,*** 61 F.3d 438 (5th Cir. 1995).

C. Written Rehabilitation Plan

We propose to add a new requirement, at §440.130(d)(3), that covered rehabilitative services for each individual must be identified under a written rehabilitation plan. This rehabilitation plan would ensure that the services are designed and coordinated to lead to the goals set forth in statute and regulation (maximum

reduction of physical or mental disability and restoration to the best possible functional level). It would ensure transparency of coverage and medical necessity determinations, so that the beneficiary, and family or other responsible individuals, would have a clear understanding of the services that are being made available to the beneficiary. In all situations, the ultimate goal is to reduce the duration and intensity of medical care to the least intrusive level possible which sustains health. The Medicaid goal is to deliver and pay for the clinically-appropriate, Medicaid-covered services that would contribute to the treatment goal. It is our expectation that, for persons with mental illnesses and substance-related disorders, the rehabilitation plan would include recovery goals. The rehabilitation plan would establish a basis for evaluating the effectiveness of the care offered in meeting the stated goals. It would provide for a process to involve the beneficiary, and family or other responsible individuals, in the overall management of rehabilitative care. The rehabilitation plan would also document that the services have been determined to be rehabilitative services consistent with the regulatory definition, and will have a timeline, based on the individual's assessed needs and anticipated progress, for

reevaluation of the plan, not longer than one year. It is our expectation that the reevaluation of the plan would involve the beneficiary, family, or other responsible individuals and would include a review of whether the goals set forth in the plan are being met and whether each of the services described in the plan has contributed to meeting the stated goals. If it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, services and/or methods. It is important to note that this benefit is not a custodial care benefit for individuals with chronic conditions but should result in a change in status. The rehabilitation plan should identify the rehabilitation objectives that would be achieved under the plan in terms of measurable reductions in a diagnosed physical or mental disability and in terms of restored functional abilities. We recognize, however, that rehabilitation goals are often contingent on the individual's maintenance of a current level of functioning. In these instances, services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal as defined in the rehabilitation plan.

Services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not rehabilitation services.

It is our further expectation that the rehabilitation plan be reasonable and based on the individual's diagnosed condition(s) and on the standards of practice for provisions of rehabilitative services to an individual with the individual's condition(s). The rehabilitation plan is not intended to limit or restrict the State's ability to require prior authorization for services. The proposed requirements state that the written rehabilitation plan must:

- Be based on a comprehensive assessment of an individual's rehabilitation needs including diagnoses and presence of a functional impairment in daily living;
- Be developed by qualified provider(s) working within the State scope of practice acts with input from the individual, individual's family, the individual's authorized health care decision maker and/or persons of the individual's choosing;
- Ensure the active participation of the individual, individual's family, the individual's authorized health care decision maker and/or persons of the individual's

choosing in the development, review and modification of these goals and services;

- Specify the individual's rehabilitation goals to be achieved, including recovery goals for persons with mental health and/or substance related disorders;
- Specify the physical impairment, mental health and/or substance related disorder that is being addressed;
- Identify the medical and remedial services intended to reduce the identified physical impairment, mental health and/or substance related disorder;
- Identify the methods that would be used to deliver services;
- Specify the anticipated outcomes;
- Indicate the frequency, amount and duration of the services;
- Be signed by the individual responsible for developing the rehabilitation plan;
- Indicate the anticipated provider(s) of the service(s)and the extent to which the services may be available from alternate provider(s) of the same service;

- Specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but not longer than one year;
- Document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan; and
- Document that the services have been determined to be rehabilitative services consistent with the regulatory definition.

We believe that a written rehabilitation plan would ensure that services are provided within the scope of the rehabilitative services and would increase the likelihood that an individual’s disability would be reduced and functional level restored. In order to determine whether a specific service is a covered rehabilitative benefit, it is helpful to scrutinize the purpose of the service as defined in the care plan.

For example, an activity that may appear to be a recreational activity may be rehabilitative if it is furnished with a focus on medical or remedial outcomes to address a particular impairment and functional loss. Such an activity, if provided by a Medicaid qualified provider, could address a physical or mental impairment that would

help to increase motor skills in an individual who has suffered a stroke, or help to restore social functioning and personal interaction skills for a person with a mental illness.

We are proposing to require in §440.130(d)(3)(iii) that the written rehabilitation plan include the active participation of the individual (or the individual's authorized health care decision maker) in the development, review, and reevaluation of the rehabilitation goals and services. We recommend the use of a person-centered planning process. Since the rehabilitation plan identifies recovery-oriented goals, the individual must be at the center of the planning process.

D. Impairments to be Addressed

We propose in §440.130(d)(4) that rehabilitative services include services provided to an eligible individual to address the individual's physical needs, mental health needs, and/or substance-related disorder treatment needs. Because rehabilitative services are an optional service for adults, a State has flexibility to determine whether rehabilitative services would be limited to certain rehabilitative services (for example, only physical rehabilitative services) or will include

rehabilitative treatment for mental health or substance-related disorders as well.

Provision of rehabilitative services to individuals with mental health or substance-related disorders is consistent with the recommendations of the ***New Freedom Commission on Mental Health***. The ***Commission*** challenged States, among others, to expand access to quality mental health care and noted that States are at the very center of mental health system transformation. Thus, while States are not required to provide rehabilitative services for treatment of mental health and substance-related disorders, they are encouraged to do so. The ***Commission*** noted in its report that, "[m]ore individuals would recover from even the most serious mental illnesses and emotional disturbances if they had earlier access in their communities to treatment and supports that are evidence-based and tailored to their needs."

Under existing provisions at §440.230(a), States are required to provide in the State plan a detailed description of the services to be provided. In reviewing a State plan amendment that proposes rehabilitative services, we would consider whether the proposed services are consistent with the requirements in §440.130(d)and section 1905(a)(13) of the Act. We would also consider whether the

proposed scope of rehabilitative services is "sufficient in amount, duration and scope to reasonably achieve its purpose" as required at §440.230(b). For that analysis, we will review whether any assistive devices, supplies, and equipment necessary to the provision of those services are covered either under the rehabilitative services benefit or elsewhere under the plan.

E. Settings

In §440.130(d)(5), consistent with the provisions of section 1905(a)(13) of the Act, we propose that rehabilitative services may be provided in a facility, home, or other setting. For example, rehabilitative services may be furnished in freestanding outpatient clinics and to supplement services otherwise available as an integral part of the services of facilities such as schools, community mental health centers, or substance abuse treatment centers. Other settings may include the office of qualified independent practitioners, mobile crisis vehicles, and appropriate community settings. The State has the authority to determine in which settings a particular service may be provided. While services may be provided in a variety of settings, the rehabilitative services benefit is not an inpatient benefit.

Rehabilitative services do not include room and board in an institutional, community or home setting.

F. Requirements and Limitations for Rehabilitative Services

1. Requirements for Rehabilitative Services

In §441.45(a), we set forth the assurances required in a State plan amendment that provides for rehabilitative services in this proposed rule. In §441.45(b) we set forth the expenditures for which Federal financial participation (FFP) would not be available.

As with most Medicaid services, rehabilitative services are subject to the requirements of section 1902(a) of the Act. These include statewideness at section 1902(a)(1)of the Act, comparability at section 1902(a)(10)(B), and freedom of choice of qualified providers at section 1902(a)(23) of the Act. Accordingly, at §441.45(a)(1), we propose to require that States comport with the listed requirements.

At §441.45(a)(2), we propose to require that the State ensure that rehabilitative services claimed for Medicaid payment are only those provided for the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level.

In §441.45(a)(3) and (a)(4), we propose to require that providers of the rehabilitative services maintain case records that contain a copy of the rehabilitation plan. We also propose to require that the provider document the following for all individuals receiving rehabilitative services:

- The name of the individual;
- The date of the rehabilitative service or services provided;
- The nature, content, and units of rehabilitative services provided; and
- The progress made toward functional improvement and attainment of the individual's goals.

We believe this information is necessary to establish an audit trail for rehabilitative services provided, and to establish whether or not the services have achieved the maximum reduction of physical or mental disability, and to restore the individual to his or her best possible functional level.

A State that opts to provide rehabilitative services must do so by amending its State plan in accordance with proposed §441.45(a)(5). The amendment must (1) describe the rehabilitative services proposed to be furnished, (2) specify the provider type and provider qualifications that

are reasonably related to each of the rehabilitative services, and (3) specify the methodology under which rehabilitation providers would be paid.

2. Limitations for Rehabilitative Services

In §441.45(b)(1) through (b)(8) we set forth limitations on coverage of rehabilitative services in this proposed rule.

We propose in §441.45(b)(1) that coverage of rehabilitative services would not include services that are furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice, or public guardianship. We also propose in §441.45(b)(1) that coverage of rehabilitative services would not include services that are intrinsic elements of programs other than Medicaid.

It should be noted however, that enrollment in these non-medical programs does not affect eligibility for Title XIX services. Rehabilitation services may be covered by Medicaid if they are not the responsibility of other programs and if all applicable requirements of the Medicaid program are met. Medicaid rehabilitative services must be

coordinated with, but do not include, services furnished by other programs that are focused on social or educational development goals and are available as part of other services or programs. Further, Medicaid rehabilitation services must be available for all participants based on an identified medical need and otherwise would have been provided to the individual outside of the foster care, juvenile justice, parole and probation systems and other non-Medicaid systems. Individuals must have free choice of providers and all willing and qualified providers must be permitted to enroll in Medicaid.

For instance, therapeutic foster care is a model of care, not a medically necessary service defined under Title XIX of the Act. States have used it as an umbrella to package an array of services, some of which may be medically necessary services, some of which are not. In order for a service to be reimbursable by Medicaid, states must specifically define all of the services that are to be provided, provider qualifications, and payment methodology It is important to note that provider qualifications for those who furnish care to children in foster care must be the same as provider qualifications for those who furnish the same care to children not in foster care. Examples of therapeutic foster care components that would not be

Medicaid coverable services include provider recruitment, foster parent training and other such services that are the responsibility of the foster care system.

In §441.45(b)(2), we propose to exclude FFP for expenditures for habilitation services including those provided to individuals with mental retardation or "related conditions" as defined in the State Medicaid Manual §4398. Physical impairments and mental health and/or substance related disorder are not considered "related conditions" and are therefore medical conditions for which rehabilitation services may be appropriately provided. As a matter of general usage in the medical community, there is a distinction between the terms "habilitation" and "rehabilitation." Rehabilitation refers to measures used to *restore* individuals to their best functional levels. The emphasis in covering rehabilitation services is the restoration of a functional ability. Individuals receiving rehabilitation services must have had the capability to perform an activity in the past rather than to actually have performed the activity. For example, a person may not have needed to drive a car in the past, but may have had the capability to do so prior to having the disability. Habilitation typically refers to services that are for the purpose of helping persons acquire new functional

abilities. Current Medicaid policy explicitly covers habilitation services in two ways: (1) when provided in an intermediate care facility for persons with mental retardation (ICF/MR); or (2) when covered under sections 1915(c), (d), or (i) of the Act as a home and community-based service. Habilitation services may also be provided under some 1905(a) service authorities such as Physician services defined at 42 CFR 440.50, Therapy services defined at 42 CFR 440.110 (such as, Physical Therapy, Occupational Therapy, and Speech/Language/Audiology Therapy), and Medical or other remedial care provided by licensed practitioners, defined at 42 CFR 440.60. Habilitative services can also be provided under the 1915(i) State Plan Home and Community Based Services pursuant to the Deficit Reduction Act of 2005. In the late 1980s, the Congress responded to State concerns about disallowances for habilitation services provided under the State's rehabilitative services benefit by passing section 6411(g) of the OBRA 89. This provision prohibited us from taking adverse actions against States with approved habilitation provisions pending the issuance of a regulation that "specifies types of day habilitation services that a State may cover under paragraphs (9)[clinic services] or (13)[rehabilitative services] of section 1905(a) of the Act

on behalf of persons with mental retardation or with related conditions." Accordingly, this regulation would specify that all such habilitation services would not be covered under sections 1905(a)(9) or 1905(a)(13) of the Act. If this regulation is issued in final form, the protections provided to certain States by section 6411(g) of OBRA 89 for day habilitation services will no longer be in force. We intend to provide for a delayed compliance date so that States will have a transition period of the lesser of 2 years or 1 year after the close of the first regular session of the State legislature that begins after this regulation becomes final before we will take enforcement action. This transition period will permit States an opportunity to transfer coverage of habilitation services from the rehabilitation option into another appropriate Medicaid authority. We are available to States as needed for technical assistance during this transition period.

In §441.45(b)(3), we propose to provide that rehabilitative services would not include recreational and social activities that are not specifically focused on the improvement of physical or mental health impairment and achievement of a specific rehabilitative goal specified in the rehabilitation plan, and provided by a Medicaid

qualified provider recognized under State law. We would also specify in this provision that rehabilitative services would not include personal care services; transportation; vocational and prevocational services; or patient education not related to the improvement of physical or mental health impairment and achievement of a specific rehabilitative goal specified in the rehabilitation plan. The first two of these services may be otherwise covered under the State plan. But these services are not primarily focused on rehabilitation, and thus do not meet the definition of medical or remedial services for rehabilitative purposes that would be contained in §440.130(d)(1).

It is possible that some recreational or social activities are reimbursable as rehabilitative services if they are provided for the purpose allowed under the benefit and meet all the requirements governing rehabilitative services. For example, in one instance the activity of throwing a ball to an individual and having her/him throw it back, may be a recreational activity. In another instance, the activity may be part of a program of physical therapy that is provided by, or under the direction of, a qualified therapist for the purpose of restoring motor skills and balance in an individual who has suffered a stroke. Likewise, for an individual suffering from mental

illness, what may appear to be a social activity may in fact be addressing the rehabilitation goal of social skills development as identified in the rehabilitation plan. The service would need to be specifically related to an identified rehabilitative goal as documented in the rehabilitation plan with specific time-limited treatment goals and outcomes. The rehabilitative service would further need to be provided by a qualified provider, be documented in the case record, and meet all requirements of this proposed regulation.

When personal care services are provided during the course of the provision of a rehabilitative service, they are an incidental activity and separate payment may not be made for the performance of the incidental activity. For example, an individual recovering from the effects of a stroke may receive occupational therapy services from a qualified occupational therapy provider under the rehabilitation option to regain the capacity to feed himself or herself. If during the course of those services the individual’s clothing becomes soiled and the therapist assists the individual with changing his or her clothing, no separate payment may be made for assisting the individual with dressing under the rehabilitation option. However, FFP may be available for optional State plan

personal care services under §440.167 if provided by an enrolled, qualified personal care services provider.

Similarly, transportation is not within the scope of the definition of rehabilitative services proposed by this regulation since the transportation service itself does not result in the maximum reduction of a physical or mental disability and restoration of the individual to the best possible functional level. However, transportation is a Medicaid covered service and may be billed separately as a medical assistance service under §440.170, if provided by an enrolled, qualified provider, or may be provided under the Medicaid program as an administrative activity necessary for the proper and efficient administration of the State's Medicaid program.

Generally, vocational services are those that teach specific skills required by an individual to perform tasks associated with performing a job. Prevocational services address underlying habilitative goals that are associated with performing compensated work. To the extent that the primary purpose of these services is to help individuals acquire a specific job skill, and are not provided for the purpose of reducing disability and restoring a person to a previous functional level, they would not be construed as covered rehabilitative services. For example, teaching an

individual to cook a meal to train for a job as a chef would not be covered, whereas, teaching an individual to cook in order to re-establish the use of her or his hands or to restore living skills may be coverable. While it may be possible for Medicaid to cover prevocational services when provided under the section 1915(c) of the Act, home and community based services waiver programs, funding for vocational services rests with other, non-Medicaid Federal and State funding sources.

Similarly, the purpose of patient education is one important determinant to whether the activity is a rehabilitative activity covered under §440.130(d). While taking classes in an academic setting may increase an individual's integration into the community and enable the individual to learn social skills, the primary purpose of this activity is academic enhancement. Thus, patient education in an academic setting is not covered under the Medicaid rehabilitation option. On the other hand, some patient education directed towards a specific rehabilitative therapy service may be provided for the purpose of equipping the individual with specific skills that will decrease disability and restore the individual to a previous functioning level. For example, an individual with a mental disorder that manifests with behavioral

difficulties may need anger management training to restore his or her ability to interact appropriately with others. These services may be covered under the rehabilitation option if all of the requirements of this regulation are met.

In §441.45(b)(4), we propose to exclude payment for services, including services that are rehabilitative services that are provided to inmates living in the secure custody of law enforcement and residing in a public institution. An individual is considered to be living in secure custody if serving time for a criminal offense in, or confined involuntarily to, State or Federal prisons, local jails, detention facilities, or other penal facilities. A facility is a public institution when it is under the responsibility of a governmental unit or over which a governmental unit exercises administrative control. Rehabilitative services could be reimbursed on behalf of Medicaid-eligible individuals paroled, on probation, on home release, in foster care, in a group home, or other community placement, that are not part of the public institution system, when the services are identified due to a medical condition targeted under the State's Plan, are not used in the administration of other non-medical programs.

We also propose to exclude payment for services that are provided to residents of an institution for mental disease (IMD), including residents of a community residential treatment facility of over 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental illness, and that does not meet the requirements at §440.160. It appears that in the past, certain States may have provided services under the rehabilitation option to these individuals. Our proposed exclusion of FFP for rehabilitative services provided to these populations is consistent with the statutory requirements in paragraphs (A) and (B) following section 1905(a)(28) of the Act. The statute indicates that "except as otherwise provided in paragraph (16), such term [medical assistance] does not include—(A) any such payments with respect to care or services for any individual who is an inmate of a public institution; or (B) any such payments with respect to care or services for any individual who has not attained 65 years and who is a patient in an IMD." Section 1905(a)(16) of the Act defines as "medical assistance" "…inpatient psychiatric hospital services for individuals under age 21…". The Secretary has defined the term "inpatient psychiatric hospital services for individuals under age 21" in regulations at §440.160 to

include "a psychiatric facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or by any other accrediting organization, with comparable standards, that is recognized by the State." Thus, the term "inpatient psychiatric hospital services for individuals under age 21" includes services furnished in accredited children's psychiatric residential treatment facilities that are not hospitals. The rehabilitative services that are provided by the psychiatric hospital or accredited psychiatric residential treatment facility (PRTF) providing inpatient psychiatric services for individuals under age 21 to its residents would be reimbursed under the benefit for inpatient psychiatric services for individuals under age 21 (often referred to as the "psych under 21" benefit), rather than under the rehabilitative services benefit.

In §441.45(b)(6), we propose to exclude expenditures for room and board from payment under the rehabilitative services option. While rehabilitative services may be furnished in a residential setting that is not an IMD, the benefit provided by section 1905(a)(13) of the Act is primarily intended for community based services. Thus,

when rehabilitative services are provided in a residential setting, such as in a residential substance abuse treatment facility of less than 17 beds, delivered by qualified providers, only the costs of the specific rehabilitative services will be covered.

In §441.45(b)(7), we propose to preclude payment for services furnished for the rehabilitation of an individual who is not Medicaid eligible. This provision reinforces basic program requirements found in section 1905(a) of the Act that require medical assistance to be furnished only to eligible individuals. An "eligible individual" is a person who is eligible for Medicaid and requires rehabilitative services as defined in the Medicaid State plan at the time the services are furnished.

The provision of rehabilitative services to non-Medicaid eligible individuals cannot be covered if it relates directly to the non-eligible individual's care and treatment. However, effective rehabilitation of eligible individuals may require some contact with non-eligible individuals. For instance, in developing the rehabilitation plan for a child with a mental illness, it may be appropriate to include the child's parents, who are not eligible for Medicaid, in the process. In addition, counseling sessions for the treatment of the child might

include the parents and other non-eligible family members. In all cases, in order for a service to be a Medicaid coverable service, it must be provided to, or directed exclusively toward, the treatment of the Medicaid eligible individual.

Thus, contacts with family members for the purpose of treating the Medicaid eligible individual may be covered by Medicaid. If these other family members or other individuals also are Medicaid eligible and in need of the services covered under the State's rehabilitation plan, Medicaid could pay for the services furnished to them.

In §441.45(b)(8), we propose that FFP would only be available for claims for services provided to a specific individual that are documented in an individual's case record.

We will work with States to implement this rule in a timely fashion using existing monitoring and compliance authority.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the Federal Register and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In

order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 440.130 Diagnostic, screening, preventative, and rehabilitative services.

This section outlines the scope of service for rehabilitative services provided by States. The services discussed in this section must be provided under a written rehabilitation plan as defined in §440.130(d)(1)(v).

Specifically, §440.130(d)(3) states that the written rehabilitation plan must meet the following requirements:

(i) Be based on a comprehensive assessment of an individual's rehabilitation needs including diagnoses and presence of a functional impairment in daily living.

(ii) Be developed by a qualified provider(s) working within the State scope of practice act with input from the individual, individual's family, the individual's authorized health care decision maker and/or persons of the individual's choosing.

(iii) Ensure the active participation of the individual, individual's family, the individual's authorized health care decision maker and/or persons of the individual's choosing in the development, review, and modification of these goals and services.

(iv) Specify the individual's rehabilitation goals to be achieved including recovery goals for persons with mental illnesses or substance related disorders.

(v) Specify the physical impairment, mental health and/or substance related disorder that is being addressed.

(vi) Identify the medical and remedial services intended to reduce the identified physical impairment, mental health and/or substance related disorder.

(vii) Identify the methods that will be used to deliver services.

(viii)Specify the anticipated outcomes.

(ix) Indicate the frequency and duration of the ervices.

(x) Be signed by the individual responsible for developing the rehabilitation plan.

(xi) Indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service.

(xii) Specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but not longer than one year.

(xiii) Be reevaluated with the involvement of the beneficiary, family or other responsible individuals.

(xiv) Be reevaluated including a review of whether the goals set forth in the plan are being met and whether each of the services described in the plan has contributed to meeting the stated goals. If it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, services and/or methods.

(xv) Document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan.

(xvi) Document that the services have been determined to be rehabilitative services consistent with the regulatory definition.

The burden associated with the requirements in this section is the time and effort put forth by the provider to gather the information and develop a specific written rehabilitation plan. While these requirements are subject to the PRA, we believe they meet the exemption requirements for the PRA found at 5 CFR 1320.3(b)(2), and as such, the burden associated with these requirements is exempt.

Section 441.45 Rehabilitative services.

Section 441.45(a)(3) requires that providers maintain case records that contain a copy of the rehabilitation plan for all individuals.

The burden associated with these requirements is the time and effort put forth by the provider to maintain the case records. While these requirements are subject to the PRA, we believe they meet the exemption requirements for the PRA found at 5 CFR 1320.3(b)(2), and as such, the burden associated with these requirements is exempt.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services,

Office of Strategic Operations and Regulatory Affairs,

Regulations Development Group,

Attn: Melissa Musotto **[CMS-2261-P],**

Room C4-26-05, 7500 Security Boulevard,

Baltimore, MD 21244-1850; and

Office of Information and Regulatory Affairs,

Office of Management and Budget,

Room 10235, New Executive Office Building,

Washington, DC 20503,

Attn: Katherine Astrich, CMS Desk Officer,

[CMS-1321-P], katherine_astrich@omb.eop.gov.

Fax (202) 395-6974.

IV. Response to Comments

Because of the large number of public comments we normally receive on Federal Register documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a final document, we will respond to the comments in that document.

V. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This is a major rule because of the size of the anticipated reduction in Federal financial participation that is estimated to have an economically significant effect of more than $100 million in each of the Federal fiscal years 2008 through 2012.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the

RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6.5 million to $31.5 million in any 1 year. The Secretary certifies that this major rule would not have a direct impact on providers of rehabilitative services that furnish services pursuant to section 1905(a)(13) of the Act. The rule would directly affect states and we do not know nor can we predict the manner in which states would adjust or respond to the provisions of this rule. CMS is unable to determine the percentage of providers of rehabilitative services that are considered small businesses according to the Small Business Administration's size standards with total revenues of $6.5 million to $31.5 million or less in any 1 year. Individuals and States are not included in the definition of a small entity.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 (proposed documents) of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital

that is located outside of a Metropolitan Statistical Area for Medicaid payment regulations and has fewer than 100 beds. The Secretary certifies that this major rule would not have a direct impact on small rural hospitals. The rule would directly affect states and we do not know nor can we predict the manner in which states would adjust or respond to the provisions of this rule.

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. Since this rule would not mandate spending in any 1 year of $120 million or more, the requirements of the UMRA are not applicable.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this rule would not impose any costs on State or local governments, preempt State law, or otherwise

have Federalism implications, the requirements of E.O. 13132 are not applicable.

B. Anticipated Effects

FFP will be available for rehabilitative services for treatment of physical, mental health, or substance-related disorder rehabilitation treatment if the State elects to provide those services through the approved State plan. Individuals retain the right to select among qualified providers of rehabilitative services. However, because FFP will be excluded for rehabilitative services that are included in other Federal, State and local programs, it is estimated that Federal Medicaid spending on rehabilitative services would be reduced by approximately $180 million in FY 2008 and would be reduced by $2.2 billion between FY 2008 and FY 2012. This reduction in spending is expected to occur because FFP for rehabilitative services would no longer be paid to inappropriate other third parties or other Federal, State, or local programs.

The estimated impact on Federal Medicaid spending was calculated starting with an estimate of rehabilitative service spending that may be subject to this rule. This estimate was developed after consulting with several experts, as data for rehabilitative services, particularly as it would apply to this rule, is limited. Given this

estimate, the actuaries discounted this amount to account for four factors: 1) the ability of CMS to effectively identify the rehabilitative services spending that would be subject to this proposal; 2) the effectiveness of CMS's efforts to implement this rule and the potential that some identified rehabilitative services spending may still be permissible under the rule; 3) the change in States' plans that may regain some of the lost Federal funding; and 4) the length of time for CMS to fully implement the rule and review all States' plans.

The actual impact to the Federal Medicaid program may be different than the estimate to the extent that the estimate of the amount of rehabilitative services spending subject to this rule is different than the actual amount and to the extent that the effectiveness of the rule is greater than or less than assumed. Because a comprehensive review of these rehabilitative services had not been conducted at the time of this estimate and because we do not routinely collect data on spending for rehabilitative services, particularly as it relates to this rule, there is a significantly wide range of possible impacts.

Thus, we are unable to determine what fiscal impact the publication of this rule would have on consumers, individual industries, Federal, State, or local government

agencies or geographic regions under Executive Order 12866. We invite public comment on the potential impact of the rule.

C. Alternatives Considered

This proposed rule would amend the definition of rehabilitative services to provide for important individual protections and to clarify that Medicaid rehabilitative services must be coordinated with but do not include services furnished by other programs that are focused on social or educational development goals and available as part of other services or programs. We believe this proposed rule is the best approach to clarifying the covered rehabilitative services, and also because all stakeholders will have the opportunity to comment on the proposed rule. These comments will then be considered before the final document is published.

In considering regulatory options, we considered requiring States to license all providers as an alternative to only requiring that providers to be qualified as defined by the State. However we believe that giving States the flexibility to determine how providers are credentialed allows for necessary flexibility to States to consider a wide range of provider types necessary to cover a variety of rehabilitation services. We believe this flexibility

will result in decreases in administrative and service costs.

We also considered restricting the rule to only include participant protections but not explicitly prohibiting FFP for services that are intrinsic elements of other non-Medicaid programs. Had we not prohibited FFP for services that are intrinsic elements of other programs, States would continue to provide non-Medicaid services to participants, the result would have been a less efficient use of Medicaid funding because increased Medicaid spending would not result in any increase in services to beneficiaries. Instead, increased Medicaid funding would have simply replaced other sources of funding.

D. Accounting Statement and Table

As required by OMB Circular A-4 (available at http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf), in the table below, we have prepared an accounting statement showing the classification of the savings associated with the provisions of this proposed rule. This table provides our best estimate of the savings to the Federal Government as a result of the changes presented in this proposed rule that Federal Medicaid spending on rehabilitative services would be reduced by approximately $180 million in FY 2008 and would be reduced by $2.24 billion between FY 2008 and

FY 2012. All savings are classified as transfers from the Federal Government to State Government. These transfers represent a reduction in the federal share of Medicaid spending once the rule goes into effect, as it would limit States from claiming Medicaid reimbursement for rehabilitation services that could be covered through other programs.

Accounting Statement: Classification of Estimated Savings, from FY 2008 to FY 2012 (in Millions)				
Category	Primary Estimates	Year Dollar	Units Discount Rate	Period Covered
Federal Annualized Monetized ($millions/ year)	443.4 ----- 441.6 ----- 448	2008 ----- 2008 ----- 2008	7% ----- 3% ----- 0%	2008-2012 ----- 2008-2012 ----- 2008-2012
From Whom to Whom?		Federal Government to State Government		

Column 1: Category – Contains the description of the different impacts of the rule; it could include monetized, quantitative but not monetized, or qualitative but not

quantitative or monetized impacts; it also may contain unit of measurement (such as, dollars). In this case, the only impact is the Federal annualized monetized impact of the rule.

Column 2: Primary Estimate – Contains the quantitative or qualitative impact of the rule for the respective category of impact. Monetized amounts are generally shown in real dollar terms. In this case, the federalized annualized monetized primary estimate represents the equivalent amount that, if paid (saved) each year over the period covered, would result in the same net present value of the stream of costs (savings) estimated over the period covered.

Column 3: Year Dollar – Contains the year to which dollars are normalized; that is, the first year that dollars are discounted in the estimate.

Column 4: Unit Discount Rate – Contains the discount rate or rates used to estimate the annualized monetized impacts. In this case, three rates are used: 7 percent; 3 percent; 0 percent.

Column 5: Period Covered – Contains the years for which the estimate was made.

Rows: The rows contain the estimates associated with each specific impact and each discount rate used.

"**From Whom to Whom?"** – In the case of a transfer (as opposed to a change in aggregate social welfare as described in the OMB Circular), this section describes the parties involved in the transfer of costs. In this case, costs previously paid for by the Federal Government would be transferred to the State Governments. The table may also contain minimum and maximum estimates and sources cited. In this case, there is only a primary estimate and there are no additional sources for the estimate.

Estimated Savings – The following table shows the discounted costs (savings) for each discount rate and for each year over the period covered. "Total" represents the net present value of the impact in the year the rule takes effect. These numbers represent the anticipated annual reduction in Federal Medicaid spending under this rule.

Estimates Savings– from FY 2008 to FY 2012 (in

Millions)

Discount Rate	2008	2009	2010	2011	2012	Total
0%	180	360	520	570	610	2,288
3%	175	339	476	506	526	2,069
7%	168	314	424	435	435	1,822

E. Conclusion

For these reasons, we are not preparing analyses for either the RFA or section 1102(b) of the Act because a comprehensive review of these rehabilitative services had not been conducted at the time of this estimate and because we do not routinely collect data on spending for rehabilitative services. Accordingly, there is a significantly wide range of possible impacts due to this rule. As indicated in the Estimated Savings table above, we project an estimated savings for of $180 million in FY 2008, $360 million in FY 2009, $520 million in FY 2010, $570 million in FY 201, and $610 million in FY 2012. This reflects a total estimated savings of $2.240 billion dollars for FY 2008 through FY 2012. We invite public comment on the potential impact of this rule.

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

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.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 440—SERVICES: GENERAL PROVISIONS

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. Section 440.130 is amended by revising paragraph (d) to read as follows:

§**440.130 Diagnostic, screening, preventative, and rehabilitative services.**

* * * * *

(d) Rehabilitative Services.

(1) Definitions. For purposes of this subpart, the following definitions apply:

(i) "*Recommended by a physician or other licensed practitioner of the healing arts*" means that a physician or other licensed practitioner of the healing arts, based on a comprehensive assessment of the individual, has—-

(A) Determined that receipt of rehabilitative services would result in reduction of the individual's physical or mental disability and restoration to the best possible functional level of the individual; and

(B) Recommended the rehabilitative services to achieve specific individualized goals.

(ii) *"Other licensed practitioner of the healing arts"* means any health practitioner or practitioner of the healing arts who is licensed in the State to diagnose and treat individuals with the physical or mental disability or functional limitations at issue, and operating within the scope of practice defined in State law.

(iii) *"Qualified providers of rehabilitative services"* means individuals who meet any applicable provider qualifications under Federal law that would be applicable to the same service when it is furnished under other Medicaid benefit categories, qualifications under applicable State scope of practice laws, and any additional qualifications set forth in the Medicaid State plan. These qualifications may include minimum age requirements, education, work experience, training, credentialing, supervision and licensing requirements that are applied uniformly. Provider qualifications must be documented in the State plan and be reasonable given the nature of the service provided and the population served. Individuals must have free choice of providers and all willing and qualified providers must be permitted to enroll in Medicaid.

(iv) *"Under the direction of"* means that for physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders (see §440.110, "Inpatient hospital services, other than services in an institution for mental diseases") the Medicaid qualified therapist providing direction is a licensed practitioner of the healing arts qualified under State law to diagnose and treat individuals with the disability or functional limitations at issue, is working within the scope of practice defined in State law and is supervising each individual's care. The supervision must include, at a minimum, face-to-face contact with the individual initially and periodically as needed, prescribing the services to be provided, and reviewing the need for continued services throughout the course of treatment. The qualified therapist must also assume professional responsibility for the services provided and ensure that the services are medically necessary. Therapists must spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice. Moreover, documentation must be kept supporting the supervision of services and ongoing involvement in the treatment. Note that this definition applies specifically

to providers of physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. This language is not meant to exclude appropriate supervision arrangements for other rehabilitative services.

(v) ***"Rehabilitation plan"*** means a written plan that specifies the physical impairment, mental health and/or substance related disorder to be addressed, the individualized rehabilitation goals and the medical and remedial services to achieve those goals. The plan is developed by a qualified provider(s) working within the State scope of practice act, with input from the individual, individual's family, the individual's authorized decision maker and/or of the individual's choosing and also ensures the active participation of the individual, individual's family, individual's authorized decision maker and/or of the individual's choosing in the development, review, and modification of the goals and services. The plan must document that the services have been determined to be rehabilitative services consistent with the regulatory definition. The plan must have a timeline, based on the individual's assessed needs and anticipated progress, for reevaluation of the plan, not longer than one year. The plan must be reasonable and

based on the individual's condition(s) and on general standards of practice for provision of rehabilitative services to an individual with the individual's condition(s).

(vi) "*Restorative services"* means services that are provided to an individual who has had a functional loss and has a specific rehabilitative goal toward regaining that function. The emphasis in covering rehabilitation services is on the ability to perform a function rather than to actually have performed the function in the past. For example, a person may not have needed to take public transportation in the past, but may have had the ability to do so prior to having the disability. Rehabilitation goals are often contingent on the individual's maintenance of a current level of functioning. In these instances services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal defined in the rehabilitation plan. Services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not within the scope of rehabilitation services.

(vii) *"Medical services"* means services specified in the rehabilitation plan that are required for the

diagnosis, treatment, or care of a physical or mental disorder and are recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. Medical services may include physical therapy, occupational therapy, speech therapy, and mental health and substance-related disorder rehabilitative services.

(viii) *"Remedial services"* means services that are intended to correct a physical or mental disorder and are necessary to achieve a specific rehabilitative goal specified in the individual's rehabilitation plan.

(2) Scope of services. Except as otherwise provided under this subpart, rehabilitative services include medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a individual to the best possible functional level. Rehabilitative services may include assistive devices, medical equipment and supplies, not otherwise covered under the plan, which are determined necessary to the achievement of the individual's rehabilitation goals. Rehabilitative services do not include room and board in an institution or community setting.

(3) Written rehabilitation plan. The written rehabilitation plan shall be reasonable and based on the individual's condition(s) and on the standards of practice for provision of rehabilitative services to an individual with the individual's condition(s). In addition, the written rehabilitation plan must meet the following requirements:

(i) Be based on a comprehensive assessment of an individual's rehabilitation needs including diagnoses and presence of a functional impairment in daily living.

(ii) Be developed by a qualified provider(s) working within the State scope of practice act with input from the individual, individual's family, the individual's authorized health care decision maker and/or persons of the individual's choosing.

(iii) Follow guidance obtained through the active participation of the individual, and/or persons of the individual's choosing (which may include the individual's family and the individual's authorized health care decision maker), in the development, review, and modification of plan goals and services.

(iv) Specify the individual's rehabilitation goals to be achieved, including recovery goals for persons with mental health and/or substance related disorders.

(v) Specify the physical impairment, mental health and/or substance related disorder that is being addressed.

(vi) Identify the medical and remedial services intended to reduce the identified physical impairment, mental health and/or substance related disorder.

(vii) Identify the methods that will be used to deliver services.

(viii) Specify the anticipated outcomes.

(ix) Indicate the frequency, amount and duration of the services.

(x) Be signed by the individual responsible for developing the rehabilitation plan.

(xi) Indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service.

(xii) Specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but not longer than one year.

(xiii) Be reevaluated with the involvement of the individual, family or other responsible individuals.

(xiv) Be reevaluated including a review of whether the goals set forth in the plan are being met and whether each of the services described in the plan has contributed to meeting the stated goals. If it is determined that there

has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, services and/or methods.

(xv) Document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan.

(xvi) Document that the services have been determined to be rehabilitative services consistent with the regulatory definition.

(xvii) Include the individual's relevant history, current medical findings, contraindications and identify the individual's care coordination needs, if any, as needed to achieve the rehabilitation goals.

(4) Impairments to be addressed. For purposes of this section, rehabilitative services include services provided to the Medicaid eligible individual to address the individual's physical impairments, mental health impairments, and/or substance-related disorder treatment needs.

(5) Settings. Rehabilitative services may be provided in a facility, home, or other setting.

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).

Subpart A—General Provisions

2. A new §441.45 is added to subpart A to read as follows:

§441.45 Rehabilitative services.

(a) If a State covers rehabilitative services, as defined in §440.130(d) of this chapter, the State must meet the following requirements:

(1) Ensure that services are provided in accordance with §431.50, §431.51, §440.230, and §440.240 of this chapter.

(2) Ensure that rehabilitative services are limited to services furnished for the maximum reduction of physical or mental disability and restoration of the individual to their best possible functional level.

(3) Require that providers maintain case records that contain a copy of the rehabilitation plan for all individuals.

(4) For all individuals receiving rehabilitative services, require that providers maintain case records that include the following:

(i) A copy of the rehabilitative plan.

(ii) The name of the individual.

(iii) The date of the rehabilitative services provided.

(iv) The nature, content, and units of the rehabilitative services.

(v) The progress made toward functional improvement and attainment of the individual's goals as identified in the rehabilitation plan and case record.

(5) Ensure the State plan for rehabilitative services includes the following requirements:

(i) Describes the rehabilitative services furnished.

(ii) Specifies provider qualifications that are reasonably related to the rehabilitative services proposed to be furnished.

(iii) Specifies the methodology under which rehabilitation providers are paid.

(b) Rehabilitation does not include, and FFP is not

available in expenditures for, services defined in §440.130(d) of this chapter if the following conditions exist:

(1) The services are furnished through a non medical program as either a benefit or administrative activity, including services that are intrinsic elements of programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice, or public guardianship.

Examples of services that are intrinsic elements of other programs and that would not be paid under Medicaid include, but are not limited to, the following:

(i) Therapeutic foster care services furnished by foster care providers to children, except for medically necessary rehabilitation services for an eligible child that are clearly distinct from packaged therapeutic foster care services and that are provided by qualified Medicaid providers.

(ii) Packaged services furnished by foster care or child care institutions for a foster child except for medically necessary rehabilitation services for an eligible child that are clearly distinct from packaged therapeutic

foster care services and that are provided by qualified Medicaid providers.

(iii) Adoption services, family preservation, and family reunification services furnished by public or private social services agencies.

(iv) Routine supervision and non-medical support services provided by teacher aides in school settings (sometimes referred to as “classroom aides” and “recess aides”).

(2) Habilitation services, including services for which FFP was formerly permitted under the Omnibus Budget Reconciliation Act of 1989. Habilitation services include services provided to individuals with mental retardation or related conditions. (Most physical impairments, and mental health and/or substance related disorders, are not included in the scope of related conditions, so rehabilitation services may be appropriately provided.)

(3) Recreational or social activities that are not focused on rehabilitation and not provided by a Medicaid qualified provider; personal care services; transportation; vocational and prevocational services; or patient education not related to reduction of physical or mental disability and the restoration of an individual to his or her best possible functional level.

(4) Services that are provided to inmates living in the secure custody of law enforcement and residing in a public institution. An individual is considered to be living in secure custody if serving time for a criminal offence in, or confined involuntarily to, public institutions such as State or Federal prisons, local jails, detention facilities, or other penal facilities. A facility is a public institution when it is under the responsibility of a governmental unit; or over which a governmental unit exercises administrative control. Rehabilitative services could be reimbursed on behalf of Medicaid-eligible individuals paroled, on probation, on home release, in foster care, in a group home, or other community placement, that are not part of the public institution system, when the services are identified due to a medical condition targeted under the State's Plan, are not used in the administration of other non-medical programs.

5. Services provided to residents of an institution for mental disease (IMD) who are under the age of 65, including residents of community residential treatment facilities more than 16 beds that do not meet the requirements at §440.160 of this chapter.

(6) Room and board.

(7) Services furnished for the treatment of an individual who is not Medicaid eligible.

(8) Services that are not provided to a specific individual as documented in an individual’s case record.

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

Dated: _____

_____

Leslie V. Norwalk,

Acting Administrator,

Centers for Medicare &

Medicaid Services

Approved: _____

_____

Michael O. Leavitt

Secretary,

BILLING CODE: 4120-01-P