§ 456.614 Inspections by utilization review committee.
A utilization review committee under subparts C through F of this part may conduct the periodic inspections required by this subpart if—
(a) The committee is not based in the facility being reviewed; and
(b) The composition of the committee meets the requirements of this subpart.

Subpart J—Penalty for Failure To Make a Satisfactory Showing of an Effective Institutional Utilization Control Program

AUTHORITY: Secs. 1102 and 1903(g) of the Social Security Act (42 U.S.C. 1302 and 1396 b(g)).
SOURCE: 44 FR 56338, Oct. 1, 1979, unless otherwise noted.

§ 456.650 Basis, purpose and scope.
(a) Basis. Section 1903(g) of the Act requires that FFP for long-stay inpatient services at a level of care be reduced, by a specified formula, for any quarter in which a State fails to make a satisfactory showing that it has an effective program of utilization control for that level of care.
(b) Purpose. This subpart specifies—
(1) What States must do to make a satisfactory showing;
(2) How the Administrator will determine whether reductions will be imposed; and
(3) How the required reductions will be implemented.
(c) Scope. The reductions required by this subpart do not apply to—
(1) Services provided under a contract with a health maintenance organization; or
(2) Facilities in which a QIO is performing medical and utilization reviews under contract with the Medicaid agency in accordance with § 431.650 of this chapter.

§ 456.651 Definitions.
For purposes of this subpart—
Facility, with respect to inpatient psychiatric services for individuals under 21, includes a psychiatric program as specified in § 441.151 of this chapter.
Level of care means one of the following types of inpatient services: hospital, mental hospital, intermediate care facility, or psychiatric services for individuals under 21.
Long-stay services means services provided to a beneficiary after a total of 60 days of inpatient stay (90 in the case of mental hospital services) during a 12-month period beginning July 1, not counting days of stay paid for wholly or in part by Medicare.


§ 456.652 Requirements for an effective utilization control program.
(a) General requirements. In order to avoid a reduction in FFP, the Medicaid agency must make a satisfactory showing to the Administrator, in each quarter, that it has met the following requirements for each beneficiary:
(1) Certification and recertification of the need for inpatient care, as specified in §§ 456.60, 456.160, 456.360 and 456.481.
(2) A plan of care established and periodically reviewed and evaluated by a physician, as specified in §§ 456.80, 456.180, and 456.481.
(3) A continuous program of utilization review under which the admission of each beneficiary is reviewed or screened in accordance with section 1903(g)(1)(C) of the Act; and
(4) A regular program of reviews, including medical evaluations, and annual on-site reviews of the care of each beneficiary, as specified in §§ 456.170, and 456.482 and subpart I of this part.
(b) Annual on-site review requirements.
(1) An agency meets the quarterly on-site review requirements of paragraph (a)(4) of this section for a quarter if it completes on-site reviews of each beneficiary in every facility in the State, and in every State-owned facility regardless of location, by the end of the quarter in which a review is required under paragraph (b)(2) of this section.
(2) An on-site review is required in a facility by the end of a quarter if the facility entered the Medicaid program during the same calendar quarter 1 year earlier or has not been reviewed since the same calendar quarter 1 year

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