

(b) The facility's utilization review committee;

(c) The agency responsible for licensing, certification, or approval of the facility for purposes of Medicare and Medicaid; and

(d) Other State agencies that use the information in the reports to perform their official function, including, if inspection reports concern IMD's, the appropriate State mental health authorities.

**§ 456.613 Action on reports.**

The agency must take corrective action as needed based on the report and recommendations of the team submitted under this subpart.

**§ 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 PRO is performing medical and utilization reviews under contract with the Medicaid agency in accordance with § 431.630 of this chapter.

[44 FR 56338, Oct. 1, 1979, as amended at 50 FR 15327, Apr. 17, 1985; 51 FR 43198, Dec. 1, 1986]

**§ 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 recipient 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.

[43 FR 45266, Sept. 29, 1978, as amended at 61 FR 38399, July 24, 1996]

**§ 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 recipient:

(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 recipient is reviewed or screened in accordance with section 1903(g)(1)(C) of the Act; and

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(4) A regular program of reviews, including medical evaluations, and annual on-site reviews of the care of each recipient, 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 recipient 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 earlier. If there is no Medicaid recipient in the facility on the day a review is scheduled, the review is not required until the next quarter in which there is a Medicaid recipient in the facility.

(3) If a facility is not reviewed in the quarter in which it is required to be reviewed under paragraph (b)(2) of this section, it will continue to require a review in each subsequent quarter until the review is performed.

(4) The requirement for an on-site review in a given quarter is not affected by the addition or deletion of a level of care in a facility's provider agreement.

(c) *Facilities without valid provider agreements.* The requirements of paragraphs (a) and (b) of this section apply with respect to recipients for whose care the agency intends to claim FFP even if the recipients receive care in a facility whose provider agreement has expired or been terminated.

[44 FR 56338, Oct. 1, 1979, as amended at 46 FR 48561, Oct. 1, 1981; 61 FR 38399, July 24, 1996]

**§ 456.653 Acceptable reasons for not meeting requirements for annual on-site review.**

The Administrator will find an agency's showing satisfactory, even if it failed to meet the annual review requirements of § 456.652(a)(4), if—

**(a) The agency demonstrates that—**

(1) It completed reviews by the end of the quarter in at least 98 percent of all facilities requiring review by the end of the quarter;

(2) It completed reviews by the end of the quarter in all facilities with 200 or more certified Medicaid beds requiring review by the end of the quarter; and

(3) With respect to all unreviewed facilities, the agency exercised good faith and due diligence by attempting to review those facilities and would have succeeded but for events beyond its control which it could not have reasonably anticipated; or

(b) The agency demonstrates that it failed to meet the standard in paragraph (a) (1) and (2) of this section by the close of the quarter for technical reasons, but met the standard within 30 days after the close of the quarter. Technical reasons are circumstances within the agency's control.

(c) Facilities that are reviewed under paragraph (b) of this section, after the quarter in which they were due for review, retain their original anniversary quarter due date for purposes of subsequent reviews.

**§ 456.654 Requirements for content of showings and procedures for submittal.**

(a) An agency's showing for a quarter must—

(1) Include a certification by the agency that the requirements of § 456.652(a) (1) through (4) were met during the quarter for each level of care or, if applicable, a certification of the reasons the annual on-site review requirements of § 456.652(a)(4) were not met in any facilities;

(2) For all mental hospitals, intermediate care facilities, and facilities providing inpatient psychiatric services for individuals under 21, participating in Medicaid any time during the 12-month period ending on the last day of the quarter, list each facility by level of care, name, address and provider number;

(3) For each facility entering or leaving the program during the 12-month period ending on the last day of the quarter, list the beginning or ending dates of the provider agreement and supply a copy of the provider agreement;

(4) If review has been contracted to a PRO under § 431.630 of this chapter, list the date the PRO contracted for review.