State Operations Manual

Chapter 4 - Program Administration and Fiscal Management

(Rev. 1, 05-21-04)

Table of Contents

Administration

4000 - Federal/State Relationship for Provider Certification

4000A - Title XVIII - Medicare Regulations

4000B - Title XIX - Medicaid Regulations

4001 - Federal Administrative Responsibilities

4002 - Nature and Source of Payments to States

4002A - Trust Funds for Title XVIII-Related Activities

4002B - Grant Funds for Title XIX-Related Activities

4003 - SA Administrative Responsibilities

4003.1 - SA Responsibility for Records and Reports

4003.2 - SA Responsibility for Staff Training and Development

4003.2A - Staff Training

4003.2B - In-Agency Training

4003.2C - Outside-of-Agency Training

4004 - SA Reporting of Possible Certification Fraud

4005 - Reliance Upon States to Initiate Budget - Coordinated Activity Plans for Carrying Out Program Action

4006 - Interagency Subagreements

4006A - Authority

4006B - Need for Subagreements With Public Entities

4006C - Program Specialization of Tasks Performed by Subagreement Entity

4006.1 - Negotiating Subagreements With Non-Public Entities

4007 - Assistance of CMS in SA Program Administration

4008 - Conflicts of Interest of SA Employees

4008A - Examples of Potential Conflicts of Interest

4008B - Report and Investigation of Improper Acts
4009 - Federal Surveyor Qualifications Standards
4009A - Persons Covered
4009B - Health Professional Qualifications
4009C - Education, Training, and Experience
4009D - Evaluation
4009E - Implementation
4009.1 - Federal Minimum Qualification Standards for LTC Facility Surveyors
4009.1A - Purpose
4009.1B - Prerequisites
4009.1C - Test Composition
4009.1D - Successful Performance
4009.1E - Unsuccessful Performance
4009.2 -Test Administration
4009.2A -Test Administration Plan
4009.2B - Staff Support
4009.2C - RO Staff Support Responsibilities
4009.3 - Test-Related Activities
4009.3A - Recordkeeping
4009.3B - Training
4010 - SA Annual Activity Plan
4011 - SA Planning Annual Workload
4018 - Regulatory Role of Surveyor and Consultant
4055 - Ordering CMS Forms and Literature

Office of Management and Budget (OMB) Approval of Information Collected from the Public

4060 - Approval of Information Collected From Public by SAs - General
4062 - Information That Does Not Require OMB Approval
4062.1 -Verification or Correction Information
4062.2 - Certifications

Survey and Certification Related Activities

4100 - Basis for Determining Health Insurance Relatedness of Activity Costs
4101 - Survey-Related Activities - General

4102 - Activities With Accredited Entities Deemed to Meet Participation Requirements

4111 - Higher Than National Standards

4115 - Non-Facility-Related Activities

4116 - SA Promotional and Public Informational Activities

4116.1 - Medical Societies

4117 - Relations with Other Programs

4131 - Deeming and Waiver of Nurse Aide Training and Competency Evaluation (NATCEP) Requirements

4132 - NATCEPs and CEPs

4132.1 - Approval of NATCEPs and CEPs

4132.1A - Requirements for Program Approval

4132.1B - Time Frames for Review

4132.1C - Prohibition of Program Approval

4132.1D - Withdrawal of Program Approval

4132.1E - Waiver of Program Prohibition

4132.1F - Conflicts of Interest

4132.2 - Requirements for NATCEPs

4132.2A - Hours of Training

4132.2B - Restrictions on Activities of Students in a NATCEP

4132.2C - Instructor Qualifications

4132.2D - Minimum Curriculum Requirements

4132.2E - Competency Evaluation Component

4132.2F - Prohibition of Charges

4132.3 - Requirements for CEP

4132.3A - Notification to Individual

4132.3B - Content of CEP

4132.3C - Administration of NACEP

4132.3D - Proctoring

4132.3E - Successful Completion of CEP

4132.3F - Unsuccessful Completion of Competency Evaluation

4140 - Guidance to States for Medicaid NF Remedies

4140A - Background

4140B - Required State Remedies

4140C - Alternative Remedies

4140D - Incentives for High Quality Care

4140E - Federal Financial Participation (FFP)

4141 – Nurse Aide Registry (NAR)

4141A - Registry Function

4141B - Registry Information

4141C - Responsibility for NAR

4145 - Specification of Resident Assessment Instruments (RAIs) for Use in Long Term Care Facilities

4145.1 - Statutory Requirements

4145.2 - Definitions

4145.3 - RAI by CMS

4145.4 - Specification of a State RAI

4145.5 - Variations in Formatting the State-Specified RAI

4145.6 - Approval Process

4146 - Minimum Data Set (MDS) System

4146.1 - System Description

4146.2 - Administration Requirements

4146.3 - Validation and Editing Process

4146.4 - Reports

4146.5 - Correction of Errors in MDS Records That Have Been Accepted by the Standard MDS System at the State

4146.6 - Replication to the CMS Repository

4146.7 - Privacy and Confidentiality

4146.7A - System of Records

4146.7B - Procedures for Disclosure of Information Pursuant to Data Use Agreement

4146.7C - Routine Uses

4146.7D - Access by an Individual to His or Her Own Records

4146.7E - Criminal Penalties for Improper Disclosure

4146.8 - System Security

4146.9 - RO Roles and Responsibilities

4146.10 - Provider Relations

SA Analysis Activity

4149 - OSCAR System

4149A - Summary

4149B - Availability of OSCAR Data

4149C - Review of Certification Data

4149D - OSCAR Input Considerations

4149E - Suggested Output Utilization

4150 - RO Oversight of SA Surveyor Training

4151 -RO Program Analysis Activity

4151A - Analysis of Administrative Factors

4151B - Analysis of SA Reviews

4151C - Analysis of Individual Special Programs

4152 – State Performance Measures for All Providers and Suppliers

4157 - Federal Monitoring Surveys - Definition and Purpose

4157A - Definition

4157B - Purpose

4157C - Scope of Survey

4157D - Survey Definitions

4158 - Federal Oversight Support Survey (FOSS) Expectations and Responsibility

4158A - SA Responsibility

4158B - RO Responsibility

4159 - Selecting and Scheduling Facilities for Monitoring Surveys

4160 - Conduct of Monitoring Surveys

Provider Certification Files and Program Reporting

4200 - SA Provider Certification Files

4205 - Materials Forwarded to RO

4210 - SA Files Used for Case Control and Reporting

4225 - Establishment of SA Case Folders and Controls

Necessary SA Expenses

4500 - General

4502 - SA Cost of Studies of Distribution of Staff Time

4504 - Pro Rata Costs - General Rule

4508 - SA Goods, Facilities, Services from Other State Agencies or From Local Agencies

4508A - Definition

4508B - Centralized State Services

4510 - SA Personnel Services

4510A - Selection of Personnel

4510B - Charges for Director and Secretary of State Survey Activities Determined by Pro Rata Method

4514 - SA Determination of Necessary Staff

4514A - Full-Time

4514B - Limitation of Full-Time Identifiable Positions

4514C - Part-Time and Temporary

4514D - Charging for Multi-Program Staff - Program Activities Readily Identifiable

4514E - Charging for Multi-Program Staff - Program Activities Not Separate

4518 - Use of Overtime in SAs

4518.1 - Payment for Overtime

4530 - SA Non-Personnel Services

4531 - Travel by SA Personnel

4531A - Certification and Administrative Travel

4531B - Training and Conference Travel

4532 - SA Communications and Supplies

4532A - Communications

4532B - Supplies

4532C - Basis for Charges

4534 - SA Office Space

4534.1 - Standard of Comparable Rental

4535 - Rent in Privately-Owned Space

4535A - Cancellation Clause

4535B - Lease Not Exceeding One Year

4535C - Consulting RO

4536 - Space in Publicly-Owned Buildings

4537 - SA Repairs and Alterations

4537A - Maintenance Repairs

4537B - Major Repairs and Replacements

4537C - Alterations
4538 - SA Identifiable (Direct) Costs
4539 - SA Office Maintenance
4540 - SA Equipment
4540A - Definition and Quality of Office Equipment
4540B - Title to and Accountability
4540C - Purchase of Equipment
4540D - Rental of Equipment
4541 - SA Retirement and Social Security
4542 - Other SA Expenses
4542.1 - Consultants Expenses
4542.2 - SA Expenses for Training of SA Personnel
4542.2A - Funding
4542.2B - Requesting Approval
4542.2C - Justification for Attendance
4542.2D - Fiscal and Reporting Considerations
4542.2E - Educational and Training Leave
4542.2F - Agreements by Employees to Continue on Job
4542.3 - Miscellaneous SA Expenses
4542.3A - Bonding
4542.3B - Public Liability
4543 - NAR/NATCEP
4544 - LTC Facility Workload (SNF/NF)

The Budgetary Process

4600 - SA Budget Request
4605 - Developing SA Budget Justification
4610 - Line Item Justification for SA Personnel Services
4611 - Line Item Justifications for SA Direct and Indirect Costs
4612 - Preparation of State Agency Budget List of Positions, Form CMS-1465a (Exhibit 47)
4614 - Preparation of State Agency Schedule for Equipment Purchase, Form CMS-1466 (Exhibit 54)

4625 - Preparation of State Survey Agency Budget Request - Non-Long-Term Care, Form CMS-435 (Exhibit 45)

4626 - Preparation of State Survey Agency Budget Request - Long-Term Care, Form CMS-435 (Exhibit 45)

4627 - Preparation of the State Survey Agency Certification Workload Report - Form CMS-434 (Exhibit 52)

4628 - Preparation of Budget Request

4629 - Developing Budget Recommendations - RO Procedures

4630 - Notification of Approval

4636 - RO Distribution of Approved Funds

4636.1 - Disbursement of Approved Funds

4640 - Need for Additional Title XVIII and Title XIX Funds

4640.1 - Title XVIII Supplemental Budgets

4642 - RO Monitoring of SA Fiscal Budgets

Financial Accounts and Reporting

4700 - SA Accounts

4701 - Supports for SA Expenditures

4710 - SA Financial Reporting

4711 - Cash Basis

4712 - SA Limit on Expenditures

4714 - Periodic Analysis of Accounts

4716 - Cash Balances and Expenditure Authority

4718 - Un-Liquidated Obligations

4719 - Nothing to Report on a Given Line

4740 - State Survey Agency Quarterly Expenditure Report, Form CMS-435, and State Survey Agency Certification Workload Report, Form CMS-434 – Preparation and Due Date

4760 - Preparation of State Survey Agency Non-Long-Term Care Quarterly Expenditure Report, Form CMS-435 (Exhibit 45)

4766 - Preparation of State Survey Agency Quarterly Expenditure Report, Long-Term Care Facility Workload, Form CMS-435

4766A - Preparation of State Survey Agency Quarterly Expenditure Report, MDS, Form CMS-435

4766B - Preparation of State Survey Agency Quarterly Expenditure Report, OASIS, Form CMS-435

4767 - Initial Survey Activity Reports

4767A - Preparation of Report on State Initial Survey Activity

4767B - Preparation of Aging Report on Pending Initial Survey Activity

Section 1864/Section 1903(a) Fiscal Audits

4780 - Scope of Audit

4781 - Objectives of Audit

4782 - Records to Be Reviewed

4784 - RO Role During Audit Process

4784A - Pre-Audit

4784B - During Audit

4784C - At Exit Conference

4785 - Draft and Pre-Release Audit Report to RO

4786 - Final Audit Report and Final Determination - RO Procedures

4786A - General

4786B - Timeliness of Final Audit Resolutions

4787 - RO Review of SA Response

4787A - Contacting SA

4787B - Timely Response

4787C - Consideration of Supporting Arguments and Information

4787D - Agreements and Disagreements

4787E - Program Findings and Recommendations

4788 - SA Disallowance Appeals

4788.1 - Medicare Disallowance Appeals

4788.2 - Medicaid Disallowance Appeals

4789 - RO Documentation of Agreements on Actions to Correct Audit Deficiencies

4790 - General Rules on Cost Allowability - RO Procedures

4790A - Cost Allowability

4790B - Exceptions to Cost Allowability Rules

4790.1 - Determinations of Overpayment - RO Procedures

4790.2 - Determination and Computation of Dollar Amounts - Use of Estimates - RO Procedures

4790.3 - Time Period for Computing Disallowances - RO Procedures

4790.4 - Inability to Determine Dollar Amounts - RO Procedures

4790.4A - Supporting Costs By Alternative Means or Developing Reasonable Estimate of Unallowable Costs

4790.4B - Costs Have Not Been Supported

4791 - RO Documentation of Agreements to Effectuate Repayments

4791.1 - Repayment Not Made Within 30 Days of Agreement Letter - RO Procedures

4792 - Audit Disallowance Actions - RO Notification

4792.1 - Non-Audit Medicare and/or Medicaid Disallowances - RO Procedures

4792.1A - Preparation of Case File

4792.1B - Assignment of File Control Number

4792.1C - Preparation Draft Disallowance Letter

4792.1D - Circulation Draft Disallowance Action for Review

4792.1E - Signature of Disallowance Letter

4792.1F - Notification of CMS

4792.1G - Disallowance Letter to Appropriate Recipients

4793 - Establishing Records Supporting Non-Audit Medicare and/or Medicaid Disallowance Actions - RO Procedures

4793A - Disallowance Analysis Memorandum (DAM)

4793B - Claim-Related Work Papers

4793C - Citations of Authority

4794 - Collections - RO Procedures

4794A - Processing Collections

4794B - Appeal Will Suspend Collection Action

4794C - Calculating Interest Charges

4794C1 - Interest on Medicare Disallowance

4794C2 - Interest on Medicaid Disallowance

4794C3 - Interest Rates

4794C4 - Date of Payment

4794D - Periodic Notices of Amounts Still Due

4794.1 - Accounts Payable - RO Procedures

4795 - Audit Clearance Document - RO Procedures

4795.1 - RO Preparation and Processing Audit Clearance Document

4795.1A - Part I - Decisions by CMS

4795.1B - Part II - Recommendations Remaining Open

4795.1C - Attachments

4795.1D - Amended ACDs

4795.1E - Dispatching ACD

4795.1F - CO Action

4795.2 - Clearing Audit Clearance Document - RO Procedures

4795.3 - Closure Versus Clearance - RO Procedures

4796 - Audit Findings and Recommendations Remaining Open at End of Four Months - RO Procedures

Disposition of Medicare and Medicaid Records

4800 - Retention and Destruction of Medicare and Medicaid Records

4801 - Provider Certification Records

4802 - Budget and Financial Report Files- Records to Be Retained

4803 - Title XVIII State Agreements

4804 - Title XIX State Plans

4805 - SA Review Files

4806 - Destruction of Records

Administration

4000 - Federal/State Relationship for Provider Certification

(Rev. 1, 05-21-04)

4000A - Title XVIII - Medicare Regulations

(Rev. 1, 05-21-04)

Section 1864 of the Social Security Act (the Act) outlines the functional role of State survey agencies (SAs) in the Medicare program, and provides for establishing an administrative relationship based upon a formal agreement negotiated between the governor of the State and the Secretary of HHS.

4000B - Title XIX - Medicaid Regulations

(Rev. 1, 05-21-04)

Pursuant to Title XIX, the SA is a grantee of Federal funds, and is required under §1902 of the Act to develop and adhere to its own administrative "State plan," for which HHS provides the major share of financing through grants, the terms of which are spelled out in §1903 of the Act. The Federal share is termed Federal financial participation (FFP). If the Secretary finds that a State is not complying with its plan (as approved by the Secretary), §1904 of the Act provides that FFP can be reduced or withheld.

Extensive regulatory standards for the development and terms of the State plans, for the management of the grants, and for the standards limiting participation of health care institutions are found in 42 CFR Chapter IV, Subchapter C. However, those regulations which directly affect the State component administering the Medicaid program (known as the State Medicaid agency or the single State agency) are widely dispersed through Subchapter C. Provisions of Federal grant laws other than title XIX also impinge upon the financial administration of the SA.

4001 - Federal Administrative Responsibilities

(Rev. 1, 05-21-04)

Among the responsibilities of the parties to the agreements are obligations imposed upon the Federal government (delegated to CMS) dealing with the States' program administration, which include:

- Setting policy and providing policy interpretations on the provider and supplier certification program standards;

- Providing consultation to agencies involved in administering the Federal requirements;

- Paying the appropriate and allowable costs of the SA functions relating to administration of regulations and provisions of the agreement and State Plan;

- Making determinations of allowable State costs to submit for Federal payment;

- Controlling payment of Federal trust funds (and grant awards) to appropriate SA for survey and certification costs incurred in administering title XVIII and title XIX programs; and

- Approving qualified State personnel used in the provider certification program.

4002 - Nature and Source of Payments to States

(Rev. 1, 05-21-04)

4002A - Trust Funds for Title XVIII-Related Activities

(Rev. 1, 05-21-04)

Execution of an agreement with a SA under §1864 of the Act involves the assumption by CMS of the obligation to meet the necessary and reasonable expenses of performing services provided for in the agreement. Payments to States under §1864 of the Act are made from the Federal Hospital and Supplementary Medical

Insurance Trust Funds to cover the costs of services performed under the agreement are authorized by §1864 of the Act. The costs of health insurance benefits and the administrative costs of the program are charged to the Trust Funds. Administrative expenses (including advances or payment to States under §1864 of the Act) are authorized for expenditure from the Trust Funds only through the regular appropriation process of Congress.

4002B - Grant Funds for Title XIX-Related Activities

(Rev. 1, 05-21-04)

Sections 1903(a)(4) and (a)(7) provide that to the extent the SA is performing certification activities pursuant to an approved State plan, the Federal financial grant mechanisms are used to pay the State for a percentage of the cost of those activities during each quarter of the year. The matching grants come from appropriated general revenues of the United States. The Secretary is authorized to pay a percentage against these costs for the proper and efficient administration of the State plan. Whereas the title

XVIII trust funds are controlled under terms of the State agreement, the grant funds are controlled by the established rules of Federal grant laws and regulations.

4003 - SA Administrative Responsibilities

(Rev. 1, 05-21-04)

The SA is responsible for:

- Establishing and maintaining organizational relationships with other State and local governmental groups as necessary for attaining program or related program goals;
- Keeping CMS advised of program needs and trends, and of responsive actions taken;
- Providing the material, equipment, and the training and support of personnel to perform the above functions; and
- Furnishing necessary records and accounting to provide justification for costs claimed for payment by the Secretary.

4003.1 - SA Responsibility for Records and Reports

(Rev. 1, 05-21-04)

The SA establishes and maintains basic records and prepares operating reports to reflect essential administrative and fiscal data of mutual concern to the SA and CMS. These records and reports provide:

- Evaluation of the effectiveness of program operations;
- Analysis of workloads;
- Identification of administrative or technical problem areas;
- Development and justification of budget estimates; and
- Supporting documentation for the expenditure of Federal and State funds.

For the most part, the SA responsibility for records and reports, on a continuing or special request basis, is limited to those pertinent to the managing of agency operations and those that reflect the agency's workload. To the extent possible, these will be designed to fit within the framework of the SA operations. The CMS requirement for a

minimum of specific records and reports is not intended to limit in any way the SA fiscal and administrative practices.

4003.2 - SA Responsibility for Staff Training and Development

(Rev. 1, 05-21-04)

4003.2A - Staff Training

(Rev. 1, 05-21-04)

All health facility surveyors employed in the Medicare and/or Medicaid programs must successfully complete the Basic Health Facility Surveyor Training Course within the first year of employment. When applicable, the surveyor must also attend laboratory, LSC, ESRD, and other specified training as necessary or required by the Federal government.

Each State is responsible for providing continuing education to its surveyors. In conjunction with and subject to the approval of the Regional Training Administrator, each SA must have a procedure for identifying the training needs of its surveyors. Each SA provides the appropriate training through in-service education, State, regional, and/or national conferences, seminars and workshops, and related courses as needed and appropriate within fiscal limitations approved by CMS. The SAs are to assure that surveyors are trained to survey for all regulatory requirements and have the necessary skills to perform the survey.

4003.2B - In-Agency Training

(Rev. 1, 05-21-04)

Each SA must have its own program of staff development that responds to the needs of new employees for orientation and basic training, and to the needs of experienced employees for continuing development and education.

4003.2C - Outside-of-Agency Training

(Rev. 1, 05-21-04)

In evaluating the appropriateness of any outside training activity for survey and certification funding, the SA and CMS must consider the degree to which the benefit to the trainee is applied toward his/her service to the survey and certification program. This is especially important where personnel are serving on a part-time basis.

4004 - SA Reporting of Possible Certification Fraud

(Rev. 1, 05-21-04)

Section 1128.B of the Act and P.L. 104.191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains specific penalties for fraud and abuse under Medicare and Medicaid. It provides criminal penalties for:

- Making false statements or representation for any benefit or payment under Medicare and Medicaid;
- Soliciting or receiving any kickback, bribe, or rebate;
- Making false statements or representations with respect to the conditions or operation of any institution, facility, or entity in order to qualify (either initial certification or recertification) for participation in Medicare or Medicaid;
- Charging for any services provided to a patient under Medicaid at a rate in excess of the established State rate, or charging, soliciting, accepting, or receiving in addition to any amounts otherwise required to be paid under Medicaid, any gift, money, donation, or other consideration as a precondition of admitting a patient to a hospital, NF, or ICF/MR, or a requirement for the patient's continued stay in such a facility;
- Charging for services not rendered; and
- Physicians and suppliers who agree to accept assignment and violate the terms of that agreement.

When the SA believes that there may be certification fraud, it should immediately notify the RO via memorandum. This memorandum should include the name and provider number of the facility, together with a statement of the relevant facts. In addition, the SA should make no further contacts with the offending individual or facility with respect to this matter unless requested to do so by the appropriate RO personnel. This is necessary because any unauthorized contacts may compromise the potential or pending investigation, including chances for successful prosecution of any criminal violation that has occurred.

4005 - Reliance Upon States to Initiate Budget - Coordinated Activity Plans for Carrying Out Program Action

(Rev. 1, 05-21-04)

States are encouraged to conduct their administrative affairs to harmonize, within broad Federal guidelines, with their own programmatic resources, recognized needs, and

accustomed methods of operation. State-initiated proposals are considered within certain limits for adoption or approval by the CMS. They are evaluated for efficiency in attaining program objectives, and for general administrative prudence and accountability.

4006 - Interagency Subagreements

(Rev. 1, 05-21-04)

4006A - Authority

(Rev. 1, 05-21-04)

When an SA wishes to assign part of its responsibility to another State or local public agency or a private agency, the authority to seek such assignment is found in the agreements of State plans negotiated by the States and the Secretary of HHS in Article IV of the §1864 Agreement.

> With prior written authorization of the Secretary, the State may utilize the services, facilities, and records of any other State agency or any local governmental agency to assist the State survey agency in carrying out its functions authorized by this Agreement. Only the reasonable and necessary costs incurred by such agencies in furnishing to the State survey agency such services, facilities, or records, may be allowed under this Agreement, in accordance with Article IX.

4006B - Need for Subagreements With Public Entities

(Rev. 1, 05-21-04)

The consideration contained in subsection A.3 of the §1864 Agreement does not apply where use of individuals or services not an integral part of the SA are generally obtained by detail or reassignment within State government. Neither would the consideration contained in subsection A.3 apply where licensure responsibility is delegated to local entities, when a pattern of close administrative relationships has been established. In such situations, no formal agreement is necessary, except where required by State practice. The necessary costs of services are identified in the normal manner used by the SA for survey and certification activities.

The fact that the activities are decentralized would not in itself require an assignment of responsibility, provided decentralization is an integral part of the SA. If the SA has already established operating arrangements with the local agency under State law and supervises local health department activities, or generally oversees these activities through conditional financial assistance similar to Federal-State grants-in-aid, no formal agreement is needed, and the costs of the services should be identified and reported in the normal manner.

There may be situations, however, in which the SA finds it desirable to arrange for services which it would not directly supervise, but over which it would maintain a certain amount of control. This might occur when the SA wishes to delegate survey functions to a local health department, yet retain the authority to make final evaluation of recommendations and forward certifications to CMS.

The SA would need to enter into an agreement with the local health department setting forth the responsibilities of both entities and enabling the department to be paid the necessary costs incurred in furnishing such services. The SA includes such costs in estimates for advance of funds and in reports of its actual expenditures.

4006C - Program Specialization of Tasks Performed by Subagreement Entity

(Rev. 1, 05-21-04)

Section 1902(a)(9) of the Act requires that the same SA that performs title XVIII certification functions must also be responsible for pursuing compliance in title XIX institutional standards. Section 1902(a)(33) of the Act provides that the State health licensing agency (which may or may not be the same agency) determines for title XIX whether institutions meet the standards for participation. The combined practical effect of these provisions is to require that the same SA make certifications for both titles XVIII and XIX. However, in no way does this preclude division of functions for inspecting and providing consultation between different State components. The important thing is that the SA designated in the §1864 State Agreement has control and responsibility for both title XVIII certification recommendations and title XIX approval decisions in all cases. As long as this is the case, it does not matter that another State or local agency is designated to perform field functions as long as the following provisions are included:

- A clear delineation of responsibilities and duties to be carried out by both parties;
- Provision for the degree of supervision and control to be exercised by the SA;
- Provision for payment by the SA on an approved cost basis;
- A termination clause specifying the length of the agreement (normally one year, with provision for extensions as necessary); and
- A statement acknowledging the applicability of the §1864 Agreement or State plan to the other agency which includes the following:

> All of the terms and provisions of the agreement or State plan between the State of (insert State) and the Secretary of Health and Human Services entered into (insert date), pursuant to §1864 or

> §1902, respectively, of the Social Security Act, as amended, which are applicable to the (insert title of State agency) also shall be applicable to the (insert title of other agency) in its performance on behalf of the (insert title of State agency) of the functions herein enumerated.

In conformity with usual State practice, the format should make provision for signatures of representatives of the two contracting agencies. Since the document relates to understandings reached at the State-local level, a representative of CMS should not make provision in the agreement for signature.

When a suitable title XVIII agreement is negotiated, two copies of the agreement are forwarded to the CMS. The CMS approval will be in the form of a separate letter from CMS and will constitute authorization for utilization of the other agency's services as provided in the agreement. Approval from CMS must be obtained whenever such an agreement is renewed or renegotiated.

4006.1 - Negotiating Subagreements With Non-Public Entities

(Rev. 1, 05-21-04)

This represents an unusual situation because arrangements with non-public organizations such as universities, hospital associations, etc., may create difficulties of program control. A unique problem might compel using a non-public agency. However, an agreement with a non-public agency would require a more precise contract than the agreement that is considered sufficient with other governmental agencies. Agreements with such agencies are not to be considered within the scope of the above sections. This is due to their complexity, and the need to ensure that the results from such non-public services are acceptable from an appeals standpoint. Not all SA agreements specify in §4006.A (A.3) that the services of non-public agencies can be utilized. Accordingly, where this is lacking, the §1864 agreement must be modified before such a request could be approved.

4007 - Assistance of CMS in SA Program Administration

(Rev. 1, 05-21-04)

The CMS RO is the representative of CMS Central Office (CO) in all certification functions and is responsible for:

- Reviewing and recommending action on SA budget submittals;
- Furnishing program guidance and policy interpretation to SA officials;
- Coordinating communications with SAs, providers, and intermediaries on certification activities; and

- Consulting on a regular basis with SAs for mutual assessment of program activities, achievement of stated objectives, and establishment of future goals.

These functions are in addition to the CMS RO Director's responsibility for assessing the adequacy of SA documentation of title XVIII certification recommendations, monitoring SA title XIX certification decisions, making the determination of acceptance for participation, denial, and termination in the title XVIII program, and for recommending the same to the RO division responsible for Medicaid.

Before approving State budget submittals, the RO considers the following:

- Is the SA's plan of program activities appropriately related to the national aims and needs of CMS programs?

- Is adequate provision made for deploying staff to accomplish these aims, and are the professional qualifications for these positions appropriate to the functions to be performed?

- Do the workload and activity plans and the staffing estimates properly distribute emphasis upon recertification, administrative and coordinative planning, and efficient agency administration in terms of supervision, training, records control, and interdivisional relationships?

- Does the budget request represent a consistent application and understanding of approved principles of reasonable cost to the SA's specific circumstances, are the requested funds proper, and has adequate provision been made for validating the costs to be charged to certification?

- Have activities not falling under the purview of survey and certification functions, such as State licensure and medical review, been appropriately excluded?

- Has the SA provided for the appropriate State match for title XIX FFP?

4008 - Conflicts of Interest of SA Employees

(Rev. 1, 05-21-04)

(Also see §7202)

Conflicts of interest may arise within the Medicare/Medicaid certification program when public employees utilize their position for private gain or to secure unfair advantages for outside associates. The gain involved may or may not be monetary. Abuses of privileged information, abuses of influence, and other abuses of trust are included, regardless of whether a monetary advantage is gained or sought. Almost all States have laws or

regulations prohibiting, and providing punishment for, overt specific violations of public trust.

It is not possible to list all situations which could be construed as potential conflicts of interest in the certification process, but many would be among the examples in subsection A, below. SA administrators should require employees to make a declaration of any such outside interests and update this declaration periodically. The SA should evaluate the need for preventive measures to protect the integrity of the certification program. In cases where certification work is performed by agencies other than the designated SA, the SA administrators and the subagency administrators have a shared responsibility for such surveillance.

It is not necessary for the SA to inform the RO of all potential and apparent conflict situations. However, if an overt abuse requires corrective action, the SA should inform the RO as described in subsection B, below.

4008A - Examples of Potential Conflicts of Interest

(Rev. 1, 05-21-04)

The following are typical situations that may raise a question of possible conflicts of interest on the part of an agency employee representing the Medicare/Medicaid survey and certification program:

- Participation in ownership of a health facility located within the employing State;
- Service as a director or trustee of a health facility;
- Service on a UR committee;
- Private acceptance of fees or payments from a health facility, group of health facilities, or association of health facility officers for personal appearances, personal services, consultant services, contract services, referral services, or for furnishing supplies to a health facility;
- Participation in a news service disseminating trade information to a segment of the health industry; and/or
- Having members of one's immediate family engaged in any of the above activities, other than non-managerial employees of health facilities.

4008B - Report and Investigation of Improper Acts

(Rev. 1, 05-21-04)

State codes should provide judicial or administrative remedies for abuses of influence, privileged information, or trust arising through conflicts of interest. Any acts of employees in violation of State laws or regulations should be handled in accordance with applicable State procedures. When there appears to be Medicare/Medicaid program involvement, the SA immediately reports this to CMS and keeps it advised of corrective actions. Also, the SA requests assistance or advice on any case of an impropriety involving conflicts of interest that cannot be handled immediately under an applicable State procedure. The regional OIG, along with the RO, will work in close cooperation with the responsible State officials to resolve the matter.

4009 - Federal Surveyor Qualifications Standards

(Rev. 1, 05-21-04)

(Also see §7201)

In accordance with the "Personnel" clause of the State agreement, SA personnel must be under a merit system that meets Federal standards. Minimum standards specifically applicable to surveyors for Medicare and Medicaid Programs are as follows:

4009A - Persons Covered

(Rev. 1, 05-21-04)

The term "surveyor" means a person who investigates, evaluates, and/or makes official reports of situations and conditions in a health facility, and who determines the degree to which the facility meets specific criteria contained in regulations issued pursuant to titles XVIII and XIX of the Act.

4009B - Health Professional Qualifications

(Rev. 1, 05-21-04)

To perform the surveyor functions requires an appropriate background in the health professions or health administration, in addition to basic investigative skills. Therefore, one element in the standard is that the surveyor be qualified in one of the following professions:

- Hospital administrator;
- Industrial hygienist;

- Laboratory or medical technologist, bacteriologist, microbiologist, or chemist;
- Medical record librarian;
- Nurse;
- Nursing home administrator;
- Nutritionist;
- Pharmacist;
- Physical Therapist;
- Physician;
- Qualified Mental Retardation Professional;
- Sanitarian;
- Social worker; or
- Any other professional category used within State merit systems for health professional positions, provided the State has determined the position classification skill level to be commensurate with any of the above professions.

This does not mean that the surveyor must belong to a professional organization or have prior work experience in the profession. It means that he/she must satisfy necessary requirements to be employed in one of these specialties by the State.

4009C - Education, Training, and Experience

(Rev. 1, 05-21-04)

To assure that individuals have the necessary knowledge, skills, and abilities to carry out survey functions, the following prerequisites apply:

- The amount of academic education required is that which is necessary to qualify in a profession listed in §4009.B;
- Newly hired surveyors must successfully complete an orientation program approved by CMS that includes the core elements of the CMS-developed orientation program. (See Exhibit 42.) The CMS provides this program for Federal surveyors and the States provide it for theirs;

- The CMS and States assure that the health facility surveyors, laboratory surveyors, and Life Safety Code (LSC) surveyors have successfully completed, within the first 12 months of employment, the basic surveyor training course developed under CMS auspices, including all course prerequisites. LSC surveyors are required to complete a LSC basic course (there is self-paced training on a CD-ROM as a prerequisite). No individual may serve on a survey team until he or she fulfills this requirement, except as a trainee who is accompanied onsite by a surveyor, who has successfully completed the required training and testing program;

- Before any State or Federal surveyor may serve on a survey team (except as a trainee) for an ICF/MR, ESRD facility, HHA, or Hospice survey, he/she must have successfully completed the relevant provider-specific Basic course and any course prerequisites;

- Some State position classifications may require additional education, training, and experience as State minimums, as requirements for promotion, or entry at a higher scale of position classification; and

- SAs must have a mechanism to identify and respond to the in-service training needs of the surveyors.

4009D - Evaluation

(Rev. 1, 05-21-04)

The surveyor must demonstrate ability to perform the essentials of the survey function, including knowledge of new or changing Federal regulations as obtained through continuing education sponsored by CMS or the State. All survey and certification staff must attend job-related training courses annually.

4009E - Implementation

(Rev. 1, 05-21-04)

Surveyors are considered qualified if:

- They undergo the training prescribed in the second and third bullets in §4009.C. Personnel are regarded as being in an associate or apprentice capacity until such time as they meet these training requirements; and

- They either devoted 50 percent or more of their working time to Medicare and/or Medicaid survey activities or meet the professional qualifications for positions described in §4009.B;

- Associates and others who are not qualified surveyors may continue to participate as members of survey teams. However, teams must include one qualified surveyor who has responsibility for completing and signing the survey report and for the accuracy of the surveys conducted by associate or apprentice surveyors.

4009.1 - Federal Minimum Qualification Standards for LTC Facility Surveyors

(Rev. 1, 05-21-04)

Sections 1819(g)(2)(C)(ii), 1819(g)(2)(E)(iii), 1919(g)(2)(C)(ii), and 1919(g)(2)(E)(iii) of the Act require that individual members of long term care (LTC) survey teams meet minimum qualifications established by the Secretary and successfully complete a training and testing program in survey and certification techniques. In addition, LTC surveyors must successfully complete a training and testing program, which includes the Surveyor Minimum Qualifications Test (SMQT).

4009.1A - Purpose

(Rev. 1, 05-21-04)

The SMQT is part of the training and testing program and addresses the knowledge, skills, and abilities (KSAs) needed to conduct standard and extended surveys in LTC facilities.

4009.1B - Prerequisites

(Rev. 1, 05-21-04)

Prior to taking the SMQT, a LTC surveyor must complete the CMS Orientation Program, and the Basic Long Term Care Health Facility Surveyor Training Course.

4009.1C - Test Composition

(Rev. 1, 05-21-04)

The SMQT is composed of two modules:

1. **Module A** – Includes the following LTC facility survey tasks:

    - Offsite Survey Preparation;

    - Entrance Conference and Onsite Preparatory Activities;

- Initial Tour;
- Resident Sampling;
- Environmental Assessment (including the environmental aspects of Dietary Services);
- Quality of Life Assessment;
- Information Analysis and Decision Making; and
- Exit Conference.

2. **Module B** – Includes:

- Resident Review (including resident assessments and plans of care);
- Closed Record Review;
- Nutritional Aspects of Dietary Services System Assessment; and
- Medications Review.

4009.1D - Successful Performance

(Rev. 1, 05-21-04)

1 - Successful Completion of Module A

An individual must successfully complete Module A to be a member of a LTC facility survey team.

Specific individual survey assignments are at your discretion.

2 – Successful Completion of Module B

Individuals who are expected by the SA to conduct the tasks addressed by Module B may survey these areas only after they successfully complete both Module A and Module B.

Specific individual survey assignments are at your discretion.

4009.1E - Unsuccessful Performance

(Rev. 1, 05-21-04)

1 - Unsuccessful Completion of Module A

Individuals who do not successfully complete Module A must retake the examination until they are successful. Test waiver procedures related to rare and extraordinary circumstances are specified in §4009.1.E.4. If a surveyor fails to successfully complete Module A, develop an individual training plan (ITP) for the surveyor to correct deficiencies. The components of the ITP are specified in §4009.1.E.3. During this period, the surveyor may participate in surveys as a trainee, i.e., the surveyor must be accompanied onsite by a surveyor who has successfully completed at least Module A of the testing and training program.

2 – Unsuccessful Completion of Module B

Individuals who do not successfully complete Module B and who are expected by the SA to conduct the LTC survey tasks addressed by Module B must successfully complete a retest of Module B. If a surveyor fails to successfully complete Module B, but has successfully completed Module A, then that surveyor may participate in surveys, but is limited to those tasks associated with Module A. He/she may continue to participate in surveys and perform Module B tasks as a trainee, i.e., an ITP is developed and the surveyor is accompanied onsite by a surveyor who has completed Module B of the testing and training program.

3 - ITP

The ITP must have the following components:

- Individual training objectives that address the area of deficiency identified by the training and testing program;
- A plan to meet training objectives;
- A schedule for meeting these objectives; and
- Someone designated to monitor the progress of the individual toward meeting these objectives.

Upon completing the ITP, the surveyor must retake modules not successfully completed.

4 - Rare and Extraordinary Circumstances

If the SA considers an individual to be a highly qualified LTC surveyor and that individual does not successfully complete an individual module after three attempts, the State Survey and Certification Director may petition the RO for an exception to that module requirement for the individual. The request must provide:

- A rationale as to why this individual has not successfully completed the module(s); and

- Evidence that the individual has full understanding of LTC requirements, guidelines, and survey procedures, and has applied them accurately, consistently, and effectively when conducting LTC surveys or accompanying the survey team. This evidence may consist of documentation of onsite evaluations of the surveyor's performance by experienced surveyors, including supervisors.

The State must include at least the following documentation in its request for an exception:

- Attestation by the State Survey and Certification Director that the individual for whom the request is being made is a highly qualified LTC surveyor;

- A rationale as to why this individual has not successfully completed the module(s); and

- Evidence that the individual has full understanding of the LTC requirements, guidelines, and survey procedures, and has applied them accurately, consistently and effectively when conducting LTC surveys or when accompanying the survey team. This evidence may consist of documentation of onsite evaluations of the surveyor's performance by experienced surveyors.

4009.2 -Test Administration

(Rev. 1, 05-21-04)

4009.2A -Test Administration Plan

(Rev. 1, 05-21-04)

1 - SA Test Plan Responsibilities

The SMQT is offered periodically at the end of the Basic LTC Health Facilities Surveyor Training Course and, based on availability of RO SMQT administrators, at RO selected sites. The CMS determines the dates for administration of the test. Before each administration of the SMQT, the RO announces the date for the test. Within 60 days, the

SA submits a test administration plan to the regional test manager. Test administration plans must:

- Include a list of individuals taking the SMQT and what module(s) they will take;
- Provide a list of proposed test sites; and
- Designate a State test coordinator and a State test monitor(s) who will assist in the administration of the test. In appointing test monitors, the SA must be aware of and avoid potential conflicts of interest.

Within 10 days from the receipt of the State test administration plan, the RO will notify RO administrators of final approved test sites.

2 - RO Test Plan Responsibilities

Before each administration of the SMQT, the RO announces the date for test administration to the State. (See Exhibit 213.) Within 60 days, the RO has the SA submit a Test Administration Plan (see Exhibit 214) to the individual the RO identifies as the contact person. Test Administration Plans must:

- Include a list of individuals taking the SMQT and what modules they will take; and designate a State test coordinator and a State test monitor(s) who will assist in the administration of the test. Test monitors appointed by the State should present no potential conflicts of interest. State test monitors may not be necessary depending on the number of individuals taking the test.

4009.2B - Staff Support

(Rev. 1, 05-21-04)

The State test coordinator and State test monitor(s) have the following responsibilities:

1 - State Test Coordinator

This individual coordinates all test administration arrangements within the State and is responsible for:

a. Establishing a list of individuals to be tested;

b. Distributing study guides to candidates;

c. Notifying candidates when and where to report for testing, and what to bring with them to the test site;

d. Providing a list of candidates who will be tested;

e. Answering questions or addressing problems that arise on the day of testing;

f. Distributing test results to individual surveyors;

g. Approving, coordinating, and monitoring training programs for individuals who do not successfully complete the test; and

h. Maintaining current records in a standardized format, e.g., dBase III Plus, for each LTC surveyor that would include the following data elements:

- Name;
- Surveyor identification number;
- Entry on duty date;
- Date the individual completed prerequisite requirements for the SMQT;
- Date(s) the individual took applicable modules of the SMQT, dates of retests; and
- Date of successful completion of the modules of the SMQT.

2 - State Test Monitor(s)

Immediately before testing, this (these) individual(s) will:

- Provide necessary test-taking materials, e.g., #2 pencils;
- Assist the regional test coordinator in monitoring the test; and
- Assist the regional test coordinator in collecting all test materials when candidates finish the examination.

3 - Test Procedures and Security

Each individual participating in the test must adhere to testing procedures established by the RO.

4009.2C - RO Staff Support Responsibilities

(Rev. 1, 05-21-04)

The RO identifies staff to manage and oversee administration of the SMQT.

1 - Test Management Activities

The RO monitors the following test management activities within its region:

- Notifying States of test date;
- Notifying State of test site;
- Reviewing and approving State Test Administration Plans;
- Assigning RO staff to oversee onsite test administration;
- Coordinating with State test coordinators to ensure that proper testing procedures are followed;
- Distributing study guides to Federal candidates and notifying them where to report for testing;
- Distributing test administration manuals to Federal test administrators;
- Providing test results to the State;
- Informing Federal surveyors of test results;
- Approving training programs for RO surveyors who do not successfully complete the test;
- Coordinating and monitoring implementation of training programs for RO surveyors who do not successfully complete the test; and
- Coordinating a record of that individual's progress toward successful completion of the training and testing program in each RO LTC surveyor's personnel file. This record should include:
    - Dates the individual completed prerequisite requirements for the SMQT;
    - Dates the individual took applicable modules of the SMQT; and
    - Dates of successful completion of the modules of the SMQT.

2 -Test Oversight Activities

The RO staff member(s) appointed to oversee onsite test administration will be trained by CO in test administration and coordination, and is responsible for activities occurring before, during, and after test administration. These activities include:

- Verifying that the correct number and kind of test materials are received;
- Securing test materials in a locked file accessible only to authorized personnel;
- Delivering the test materials of the test site on the date of testing;
- Assigning candidates to testing rooms;
- Assigning test monitor(s) to each room in a proportion of at least one test monitor to every 50 candidates or portion thereof;
- Being available to answer questions or address problems that arise on the day of testing;
- Oversight of candidate check-in;
- Oversight of onsite test administration within the test room; and
- Ensuring that materials are properly returned to the appropriate entity for scoring.

4009.3 - Test-Related Activities

(Rev. 1, 05-21-04)

4009.3A - Recordkeeping

The SA will use a standardized data base format, e.g., dBase III Plus, to structure an SMQT record for each LTC surveyor. The SA uses the database to track implementation of the training and testing program and the progress of individual surveyors toward its completion. We suggest that the SA database have the following characteristics:

(Rev. 1, 05-21-04)

Field	Field Name	Type	Width
1	LAST NAME	Character	15
2	FIRST NAME/MI	Character	12
3	SURVEYOR ID	Character	5

4	EOD	Character	8[1]
5	STATE CODE	Character	2
6	RO CODE	Character	2
7	DISC CODE	Character	2[2]
8	PREREQ COMP D	Character	8[3]
9	PRE A	Character	1[4]
10	PRE A RESULT	Character	1[5]
11	D1TEST A	Character	8[6]
12	1TEST A RESULT	Character	1[7]
13	D2TEST A	Character	8[8]
14	2TEST A RESULT	Character	1[9]
15	D3TEST A	Character	8[10]
16	3TEST A RESULT	Character	1[11]
17	PRE B	Character	1[4]
18	PRE B RESULT	Character	1[5]
19	D1TEST B	Character	8[6]
20	1TEST B RESULT	Character	1[7]
21	D2TEST B	Character	8[8]
22	2TEST B RESULT	Character	1[9]
23	D3TEST B	Character	8[10]
24	3TEST B RESULT	Character	1[11]
25	SUCCESSCOMP A	Character	8[12]
26	SUCCESSCOMP B	Character	8[12]
27	DEXTRA	Character	8[13]

[1] EOD = Date LTC surveyor was initially assigned to conduct LTC surveys. Use this format: mm/dd/yy.
[2] DISC CODE = Discipline Code. Use Surveyor Characteristics and Training Questionnaire Data codes to identify surveyor discipline.
[3] PREREQ COMP D = Date all prerequisites for the SMQT were completed. Use this format: mm/dd/yy.
[4] PRE A/B = Enter Y (Yes) or N (No) for whether or not Pre-test A/B was taken.
[5] PRE A/B RESULT = Enter S (Successfully Completed) or N (Not Successfully Completed).
[6] D1TEST A/B = Date Module A and/or B was taken for the first time. Use this format: mm/dd/yy.
[7] 1TEST A/B RESULT = Enter S (Successful) or N (Not successful) in completing Module A/B the first time taken.
[8] D2TEST A/B = Date Module A and/or B was taken for the second time. Use this format: mm/dd/yy.
[9] 2TEST A/B RESULT = Enter S (Successful) or N (Not successful) in completing Module A/B the second time taken.
[10] D3TEST A/B = Date Module A and/or B was taken for the third time. Use this format: mm/dd/yy.
[11] D3TEST A/B RESULT = Enter S (Successful) or N (Not successful) in completing Module A/B the third time taken.
[12] SUCCESSCOMP = Date Module A and/or B successfully completed. Use this format: mm/dd/yy.
[13] DEXTRA = Date successfully completed program based on extraordinary circumstances. Use this format: mm/dd/yy.

4009.3B - Training

(Rev. 1, 05-21-04)

The SA develops a standardized plan to provide training for those surveyors who do not successfully complete Module A or Module B, e.g., onsite observation of survey team, independent study, continuing education. The plan should address how the SA identifies the most effective approach for each individual in training and how it manages the individual's progress.

4010 - SA Annual Activity Plan

(Rev. 1, 05-21-04)

The SA with its budget request submits the annual activity plan; a description of planned program activities for the ensuing fiscal year. This enables CMS to assess the adequacy and appropriateness of the programs planned by the State and match those activities against the accompanying State budget.

4011 - SA Planning Annual Workload

(Rev. 1, 05-21-04)

The need for professional skills and additional personnel can only be ascertained after the workload is identified and a plan for accomplishing the work is outlined. Since the survey and certification program requires that health facilities be surveyed according to an established coverage level (with leeway permitted to spread the workload, and to integrate it with other programs, where feasible), the SA should find it helpful to set goals by numbers and categories of facilities. The activity plan should establish a program that will permit survey and certification work to be done on an orderly basis throughout the year with a workload distribution as even as possible. Additional workloads caused by amendments to title XVIII or title XIX of the Act are to be treated as separate workload items.

The SA checks the range of activities projected for the budget year to identify possible questions relating to survey and certification requirements. If it appears questions would arise, include sufficient details in the activity plan on activities to show justification for survey and certification program support.

The "State Survey Agency Certification Workload Report," Form CMS-434 (see Exhibit 52), is the vehicle for identifying the number of facilities to be surveyed during the year. It must be furnished by the SA as a supplement to the narrative activity plan in order to permit evaluation of the plan in recognition of the quantity and types of work to be accomplished.

In addition to the numbers of surveys entered on Form CMS-434, there is data available on the number of instances of certification deficiencies that the SA has identified relative to each of the Conditions of Participation (CoPs). The SA cites the data in the narrative work plan, as appropriate, to show the SA's need to engage consultants in particular specialty areas or to explain why the SA requests the Secretary's concurrence to give selective emphasis to particular facets of program activity.

4018 - Regulatory Role of Surveyor and Consultant

(Rev. 1, 05-21-04)

(Also see §2727, and Appendix P – Section 9)

The survey and certification process is intended to ascertain whether providers and suppliers meet program participation requirements. Therefore, the primary role of the surveyor is to assess the quality of care and services and relate those findings to statutory and regulatory requirements.

When deficiencies are found in the course of a survey, the surveyor should explain to the provider what the deficiency is in terms specific enough to allow a reasonably knowledgeable person to understand why the requirement is not met. In many situations, the explanation of the deficiency itself provides the necessary information needed to correct the problem. This is not considered to be consultation.

However, in some instances there may be several possible causes for the deficiency, and it is for these situations that the policy for not providing consultation is intended. It is not the surveyor's job to examine the facility's policies and procedures to determine or speculate on the root cause of deficiencies, or to sift through various alternatives to prescribe one acceptable remedy. In these situations, the provider is responsible for determining the most feasible and economical way of achieving compliance.

On resurvey, the surveyor's task is to ascertain whether compliance has been achieved and not whether the provider did what the surveyor recommended. Thus, in reviewing a proposed PoC, the SA reviews the plan only for effectiveness and timeliness.

Surveyors should be willing to explain the requirements and why something is a deficiency. For example, if a provider is cited for maintaining incomplete clinical records, the surveyor is to specify what is missing, not why it is missing or what process is best for ensuring that the records are complete in the future. Under no circumstances should a data tag or a reiteration of the regulations be used as a substitute for an explanation.

The SA staff should be willing to work with all groups in its State if such discussions or meetings lead to more meaningful surveys or an overall improvement in compliance by providers and suppliers.

4055 - Ordering CMS Forms and Literature

(Rev. 1, 05-21-04)

The Chief of the Printing Management Branch at CMS CO sends an order form to each SA every 6 months. The SA head may request a supply of forms and CMS literature sufficient to meet anticipated needs within the agency and for any necessary redistribution by the agency. Also, as new forms are devised, he/she arranges for a simultaneous advance shipment. Estimate the number of copies of new materials needed before the next regular six-month supply period and request that number directly. Shipments are by parcel post or bill of lading (never C.O.D.).

The SA should maintain an adequate supply of each required form and publication until it becomes obsolete. The SA submits interim orders any time that a supplemental supply is needed. However, since it takes approximately four weeks to fill and ship an order, the SA should submit a reorder while an eight or ten-week supply is on hand.

Address any contacts regarding the ordering of public literature or forms to:

Centers for Medicare & Medicaid Services
7500 Security Boulevard - South Building
Elizabeth Ostrowski
Form Management Specialist
Baltimore, Maryland 21244-1850

Phone: (410) 786-7863

NOTE: If the SA receives any shipment or mailing of materials in error, do not return them without first contacting the Forms Management Specialist for instructions.

Address any contacts regarding the ordering of the SOM to:

Centers for Medicare & Medicaid Services
7500 Security Boulevard - South Building
Linda Douglas
Baltimore, Maryland 21244-1850

Phone: (410) 786-7860

Office of Management and Budget (OMB) Approval of Information Collected from the Public

4060 - Approval of Information Collected From Public by SAs - General

(Rev. 1, 05-21-04)

The Paperwork Reduction Act (PRA) was enacted on December 11, 1980. Section 3512 of the Act stipulates that no member of the public may be penalized for failing to maintain or provide information to any agency if the information collection request does not display an approval number from OMB or does not state that such request is not subject to the PRA. The term "agency" includes executive departments (such as CMS) and their contractors (such as intermediaries, carriers, and SAs). The term "public" includes all entities that are not employees of or contractors to the Federal government. For CMS purposes, the public includes health care providers, suppliers, physicians, beneficiaries, QIOs, and SMAs.

The CMS forms originating from CO which reference information collection should already have OMB approval. The OMB approval number (e.g., 0938-XXXX) is printed in the upper right-hand corner of these forms. Over the years, SAs developed other forms subject to the PRA in response to instructions contained in CMS' program issuances. Thus, the actual requirement for the information resides in the program issuance manuals approved by OMB.

In some categories, the specification of data elements may unduly limit the performance of SAs. In these cases, OMB approval will be obtained for a more generalized collection of information, such as an "area of inquiry." The area of inquiry would be accompanied by examples of data elements, typical of the area of inquiry. The SAs' forms could use these data elements or others of a similar nature, as long as they fall within the area of inquiry as described in the program issuance manual and approved by OMB.

As the categories are reviewed and defined in terms of their data elements or areas of inquiry, the program issuance will convey this information. The SAs' forms will then be limited to the routine collection of the data so specified.

In the future, as CMS identifies new categories of information that SAs should collect, two areas of the program issuance manuals will be updated and reapproved by OMB. First, the forms in the exhibits will identify the new OMB approval number and the data elements that are to be collected. Secondly, the SA's responsibility in collecting this information will be described in the appropriate section of the manual.

The PRA requires the display of the OMB approval number on each form. It should be printed in the top right-hand corner of each page as shown below. No special typesetting is required.

Form Approved
OMB No. 0938-XXXX

4062 - Information That Does Not Require OMB Approval

(Rev. 1, 05-21-04)

There are a number of forms that do not come under the provisions of the PRA. The following definitions and discussion identify the types of forms that do not require OMB approval nor the display of an OMB approval number.

4062.1 -Verification or Correction Information

(Rev. 1, 05-21-04)

If a form that has OMB approval is filled out incompletely or incorrectly, the request for the missing or corrected data does not require OMB approval.

NOTE: The follow-up request is limited to those items present on the OMB-approved form. If additional items are included, the form cannot be considered approved by OMB.

This is an exception to the PRA that was granted by OMB. It has particular relevance to claims development activities, but can be invoked by OMB.

4062.2 - Certifications

(Rev. 1, 05-21-04)

A certification attests to the accuracy of a statement or the receipt of articles or services. It is limited to identifying information and a signature. A certification may include, at a maximum, the following information:

- The name, title, address, and phone number of the individual or entity making the certification;
- Any number identifying the certifier, such as the provider number, physician number, social security number, license number, tax number, or health insurance number;
- An identification of the article received, for instance, a benefit check;

- An authorization statement which, for instance, names a representative to act on one's behalf, or which identifies an entity to whom the information may be revealed;

- The statement to be certified. The statement must be printed on the form. The certifier cannot write it. It is acceptable to have more than one certification statement printed with a line/box to be checked off by the certifier; and

- A date and a signature line.

Information in excess of that described above would make the form subject to OMB review and approval.

Survey and Certification Related Activities

4100 - Basis for Determining Health Insurance Relatedness of Activity Costs

(Rev. 1, 05-21-04)

Sections 1864 and 1902 of the Social Security Act (the Act) provide the basis for agreements and plans with States under which CMS pays States for costs incurred in performing survey and certification functions The primary State function may be characterized as "certification" of health facilities, and the costs of SA activities that are an integral part of this process are appropriate for survey and certification funding.

This manual discusses the procedures involved in the certification function. The criteria contained in §§4100-4109 are controlling in terms of the nature and extent of activity that may be charged to the survey and certification program within the limits of the approved budget.

The operating procedures contained in Part Two outline activities that are required to support an initial certification that a facility does or does not qualify to participate in, or have their services covered under the survey and certification program, or a certification recommending continuing participation, coverage, or termination.

Such activities are certification-related and are funded under the survey and certification program In those agencies where activities are performed for survey and certification only, the survey and certification program pays the entire costs. In many States, these activities serve other programs in addition to survey and certification (e.g., certification as well as licensure). When this situation exists, the SA establishes a method of determining the survey and certification share of the cost. (See §§4500-4544.) Where the SA has responsibility for performing survey-related activities under title XVIII and title XIX, establish appropriate safeguards to ensure that proper charges are made to each program and that duplicate charges are avoided.

4101 - Survey-Related Activities - General

(Rev. 1, 05-21-04)

In addition to survey activity which identifies and documents deficiencies, the SA communicates CMS guidelines and explains the CoPs (or requirements for SNFs/NFs, to:

- Nonparticipating facilities or agencies that have either filed a Request to Establish Eligibility or a Request for Approval or have otherwise expressed interest in

participating in the appropriate title XVIII or title XIX certification program and which have a reasonable potential for qualifying, when surveyed; and

- Those participating providers and suppliers that have correctable deficiencies.

The information provided should be concerned with specific steps the facility must take to meet program requirements, for example, advising that medical staff bylaws need to describe the organization of the medical staff. However, the SA does not provide direct assistance (e.g., helping the facility to actually rewrite the bylaws), since direct assistance is not an agency function under §§1864 (the Agreement) or 1902 (State plan) of the Act.

The services that may be offered to facilities are subject to limitations that prohibit the program from assuming responsibilities and costs that are properly those of the facility, another agency, or another program.

4102 - Activities With Accredited Entities Deemed to Meet Participation Requirements

(Rev. 1, 05-21-04)

Section 1865 of the Act allows CMS to find that if the accreditation of the following entities by any national accreditation organization provides reasonable assurance that the CoPs or Conditions for Coverage(CoCs), or requirements for SNFs, are met for these entities, then CMS may deem these entities by virtue of their accreditation as meeting the Medicare conditions. The entities covered by the law that can be deemed are hospitals, psychiatric hospitals, ASCs, RHCs, laboratories, hospices, HHAs, SNFs, CORFs, and clinic rehabilitation agencies or public health agency providers of OPT (including speech pathology services) or occupational therapy services. Section 353 of the Public Health Service Act (PHSA) also provides the same recognition for accreditation organizations and State licensure programs of CLIA laboratories. The CMS published a notice in the Federal Register" to notify the public of any organizations whose accredited specified types of providers or suppliers are deemed to meet Medicare or CLIA participation requirements. Sample validation or substantial allegation surveys of entities accredited by accreditation organizations approved by CMS are acceptable reimbursement activity. See §1018 for those facilities that may participate by virtue of their accreditation by an approved accrediting body.

4111 - Higher Than National Standards

(Rev. 1, 05-21-04)

Section 1863 of the Act permits, at the request of a State, higher requirements for that State than the Federal Conditions or Requirements if approved under a State plan. If approved by the Secretary, the Secretary will impose like requirements in entities within that State. When a State has higher standards (approved by the Secretary) than those

imposed nationally, the costs of certification activities necessary to apply the higher requirements are paid by Federal trust fund and grant monies.

4115 - Non-Facility-Related Activities

(Rev. 1, 05-21-04)

In addition to activities that are related to individual facilities, there are other activities necessary to the proper functioning of the survey and certification program. These activities include relationships with other programs and organizations that permit effective accomplishment of program goals as they relate to individual facilities.

4116 - SA Promotional and Public Informational Activities

(Rev. 1, 05-21-04)

Most of the promotional and public informational activities are carried out by CMS, primarily through CO and ROs and, to a lesser extent, by intermediaries. However, §§1819(g)(1)(B) and 1919(g)(1)(B) of the Act require each State to conduct periodic educational programs for the staff and residents (and their representatives) of SNFs and NFs in order to present current regulations, procedures, and policies. Persons having general questions about Medicare and/or Medicaid are referred to the RO for information. Certain professional relations activities on the part of the SA's personnel are necessary and proper for maintaining ongoing relationships in the health professions. Participation by SA employees as speakers, panelists, or consultants at meetings of professional organizations (hospital associations, medical societies) in the interest of furthering compliance with Medicare and/or Medicaid standards and objectives would be proper activities for survey and certification funding.

4116.1 - Medical Societies

(Rev. 1, 05-21-04)

Contacts by SA officials with medical societies are desirable to clarify the objectives of survey and certification program and enlist the cooperation of the medical societies in meeting those objectives that are certification-related.

Objectives may relate to a specific CoP or CoC or to broader objectives such as effective use of the different levels of care offered through hospitals, LTC facilities, HHAs, and other medical facilities.

4117 - Relations with Other Programs

(Rev. 1, 05-21-04)

It is incumbent on each State to maintain effective liaison with other programs having activities similar to those performed for the survey and certification program. The need for establishing and maintaining relationships is particularly obvious with reference to licensure programs. In addition to licensure, examples of other programs with goals closely related to those of certification are hospital survey and construction programs, health facilities planning programs, and mental health and chronic ESRD programs. These programs, while not bearing the same relationship to survey and certification as does licensure, include activities that approximate health insurance activities. Additionally, the SA should consider joint activities with mutually benefiting programs on an "ad hoc" basis. This assumes that each State makes protracted and frequent contacts at an administrative level in the interest of the survey and certification program.

4131 - Deeming and Waiver of Nurse Aide Training and Competency Evaluation (NATCEP) Requirements

(Rev. 1, 05-21-04)

The Omnibus Budget Reconciliation Act (OBRA) of 1987 prohibits SNFs and NFs from using as nurse aides any individuals who have not successfully completed a nurse aide training and competency evaluation program (NATCEP) or competency evaluation program (CEP) approved by the State. The OBRAs 1987 and 1989 deemed some individuals to meet this requirement and permitted States to waive this requirement for others. All individuals who are deemed to meet the nurse aide NATCEP requirements, or for whom the State waives the requirement to complete a CEP, must be included in the nurse aide registry described in §4141.

A nurse aide is deemed to satisfy the requirement of completing a NATCEP if, before July 1, 1989, he or she completed a nurse aide training and CEP of at least 60 hours and made up at least the difference between the number of hours in the program he or she completed and 75 hours in supervised practical nurse aide training, or in regular in-service nurse aide education.

A nurse aide is deemed to satisfy the requirement of completing a NATCEP if, before July 1, 1989, the individual was found competent (whether or not by the State) after completing nurse aide training of at least 100 hours duration.

The State may deem an individual to have completed a NATCEP if the individual completed, before July 1, 1989, a NATCEP that it determines would have met the requirements for approval at the time it was offered.

The State may waive the requirement for an individual to complete a CEP for any individual who can demonstrate to its satisfaction that he or she has served as a nurse aide at one or more facilities of the same employer in the State for at least 24 consecutive months before December 19, 1989.

Any individual described above may be employed as a nurse aide by a nursing home if that individual is also competent to perform nursing or nursing-related services.

4132 - NATCEPs and CEPs

(Rev. 1, 05-21-04)

The OBRA of 87 requires the State to specify those NATCEPs and CEPs it approves. The State should follow the requirements detailed in §4132.1 - 4132.3 when reviewing and approving programs, and when withdrawing approval from programs. The State may offer its own NATCEP and/or CEP as long as the program meets these requirements.

4132.1 - Approval of NATCEPs and CEPs

(Rev. 1, 05-21-04)

If the State does not offer a NATCEP or CEP, the State should review and approve or disapprove all NATCEPs, upon request. The State should approve NATCEPs and CEPs offered by any entity as long as the requirements for approval are met.

4132.1A - Requirements for Program Approval

(Rev. 1, 05-21-04)

Before approving a NATCEP or CEP, the State should:

- For NATCEPs, determine whether the requirements of §4132.2 are met;
- For CEPs, determine whether the requirements of §4132.3 are met; and
- In all reviews other than the initial review, visit the entity providing the program.

4132.1B - Time Frames for Review

(Rev. 1, 05-21-04)

Within 90 days of a request to review a program or receipt of additional information from a requester, the State must:

- Advise the requestor whether the program has been approved; or

- Request additional information.

The State may not grant approval of a program for more than 2 years. The State should require programs to notify the State when there are substantive changes to the program within the two-year period, and the State should review programs to which substantive changes are made.

4132.1C - Prohibition of Program Approval

(Rev. 1, 05-21-04)

Unless program disapproval is waived in accordance with subsection E below, the State must not approve a NATCEP or nurse aide CEP offered by or in a nursing home if, in the 2 years prior to the State's review, that facility:

- In the case of a skilled nursing facility, has operated under a waiver under §1819(b)(4)(C)(ii)(II) of the Act;

- In the case of a nursing facility, has operated under a waiver under §1919(b)(4)(C)(ii) of the Act that was granted on the basis of a demonstration that the NF is unable to provide nursing care required under §1919(b)(4)(C)(i) of the Act for a period in excess of 48 hours a week;

- Has been subject to an extended (or partial extended) survey under §§1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act;

Has been assessed a civil money penalty described in §§1819(h)(2)(B)(ii) or 1919(h)(2)(A)(ii) of the Act of not less than $5,000. This requirement applies to civil money penalties for Federal citations only after the facility has had an opportunity to a hearing as specified in §1128A of the Act and the penalty is determined due and payable; or

- Has been subject to a remedy described in §§1819(h)(2)(B)(i) or (iii), 1819(h)(4), 1919(h)(1)(B)(i), or 1919(h)(2)(A)(i), or (iii), or (iv) of the Act.

4132.1D - Withdrawal of Program Approval

(Rev. 1, 05-21-04)

Unless the State waives program disapproval in accordance with subsection E below, the State must withdraw approval from:

- Any NATCEP or CEP described in subsection C; and

- Any NATCEP or CEP if the entity offering the program refuses to permit unannounced State visits. (Also, any facility that refuses to permit unannounced State visits is subject to having its provider agreement terminated, and being excluded from the program by the Office of the Inspector General.)

The State may withdraw approval of a NATCEP or CEP if the State determines that any of the requirements described in §§4132.2 and 4132.3 are not met by the program. The State may also withdraw approval from any program that does not meet any requirements the State may have in excess of the minimum Federal requirements, or that otherwise fails to meet State standards.

When withdrawing approval from a NATCEP or a CEP, the State should:

- Notify the program in writing, indicating the reason(s) for withdrawal of approval; and

- In the case of a NATCEP, permit students who have already started the program to finish it.

4132.1E - Waiver of Program Prohibition

(Rev. 1, 05-21-04)

A State may waive the disapproval of programs offered in (but not by), certain nursing homes if the State does all of the following:

a. Determines that there is no other such program offered within a reasonable distance of the facility. Generally, "reasonable distance" is considered as any distance that could be traveled within approximately 1 hour from the facility, factoring in the typical mode of transportation for staff in the area. Exceptions to what generally is considered to be "reasonable distance" would be at the discretion of the State;

b. Assures, through an oversight effort that an adequate environment exists for operating the program in the facility. States are encouraged to accomplish this oversight effort in consultation with, for example, a local school of nursing. An "adequate environment" is considered to exist if the facility has no deficiencies that constitute substandard quality of care at the time of its request for a disapproval waiver. An "oversight effort" is considered to exist if the State has a process in place to assure that the facility has no deterioration in care that results in substandard quality of care during the waiver period, and that the facility otherwise continues to meet the waiver criteria during the waiver period; and

c. Provides notice of such determination and assurances to the State long-term care ombudsman. States are encouraged to also publish such a notice for residents and potential residents.

Duration of Waiver - A waiver may not exceed 2 years, but must be withdrawn earlier if the facility is subsequently found to no longer meet the waiver criteria. If 2-year disapproval periods overlap, any non-waived disapproval in the earlier period will control waiver rights in the second until the two periods no longer overlap. Below are examples describing the effect of a series of survey findings on a facility's ability to have a waiver.

EXAMPLE:

Year 1:

A survey conducted at Facility X identifies substandard quality of care. The finding of substandard quality of care results in nurse aide training and competency evaluation program disapproval for 2 years. The facility requests and is granted a waiver after the State has confirmed that the facility has removed the substandard quality of care. The waiver may not exceed 2 years.

Year 2:

The survey of Facility X identifies substandard quality of care. Based on this current finding of substandard quality of care, the facility loses its existing waiver. This nurse aide training and competency evaluation program disapproval, based on this survey, is effective for 2 years. Additionally, the facility forfeits the waiver granted in year 1 due to its inability to continue to meet waiver criteria at E.1.b. (i.e., to be free of deficiencies which constitute substandard quality of care.

Year 3:

The survey of Facility X identifies deficiencies that do not constitute substandard quality of care, but result in the imposition of denial of payment for new admissions. The imposition of this remedy results in nurse aide training and competency evaluation program disapproval for 2 years. The facility requests and is granted a waiver. The waiver may not exceed 2 years. However, since the facility is currently operating under a nurse aide training and competency evaluation program disapproval for 2 years, based on its year two survey, the waiver resulting from this current survey will not apply until the remainder of the disapproval period (which overlaps with part of the waiver period) is satisfied.

4132.1F - Conflicts of Interest

(Rev. 1, 05-21-04)

States are governed by their respective conflict of interest laws and are free to develop their own policies or rules about what may or may not constitute a conflict of interest relative to nurse aide training and competency evaluation programs. This gives States the

ability to define their programs so that they can meet their needs relative to NATCEPs while meeting the intent of the law. Factors States may consider in making conflict of interest determinations may include, but are not limited to, the following:

- Whether the training program being offered is owned and operated independently of the ownership and operation of the nursing home that has lost its ability to train;

- Whether facility staff, who are also employees of an approved outside training program, should be permitted to train in the facility (as employees of the outside training program) if the facility loses its ability to train; and

- Any other factors the State believes to be relevant in making conflict of interest determinations.

4132.2 - Requirements for NATCEPs

(Rev. 1, 05-21-04)

(S&C01-20)

4132.2A - Hours of Training

(Rev. 1, 05-21-04)

A NATCEP must consist of a minimum of 75 clock hours of training in order to be approved by the State. The State has the discretion to require additional hours of training.

NOTE: Transporting residents is the only nursing home service that does not require the use of nurse aides with 75 hours of training. It was never the intent that transporting residents by driving a van or pushing a wheelchair would require 75 hours of nurse aide training. However, transferring residents, for example from bed to wheelchair, from wheelchair to the toilet or bath does require the services of a nurse aide who has completed the NATCEP.

4132.2B - Restrictions on Activities of Students in a NATCEP

(Rev. 1, 05-21-04)

The State should not approve a program unless it ensures that:

- Students do not perform any services for which they have not trained and been found proficient by the instructor; and

- Students providing services to residents are under the general supervision of a licensed nurse or an RN.

4132.2C - Instructor Qualifications

(Rev. 1, 05-21-04)

The training of nurse aides must be performed by or under the general supervision of a registered professional nurse who possesses a minimum of 2 years of nursing experience, at least one year of which must be in the provision of long-term care facility services. Instructors of nurse aides must have completed a course in teaching adults or have experience in teaching adults or supervising nurse aides. In a facility-based program, the training of nurse aides may be performed under the general supervision of the Director of Nursing, who is prohibited from performing the actual training.

Other individuals may supplement the instructor. Following are examples of those who might be useful in a NATCEP:

- RNs;
- Licensed practical/vocational nurses;
- Pharmacists;
- Dietitians;
- Social workers;
- Sanitarians;
- Fire safety experts;
- Nursing home administrators;
- Gerontologists;
- Psychologists;
- Physical and occupational therapists;
- Activities specialists;
- Speech/language/hearing therapists; and
- Resident rights experts.

The program may utilize individuals from fields other than those listed as examples if needed to meet the planned program objectives for a specific unit. Supplemental personnel must have a minimum of one year of experience in their fields. The State may require that these individuals be, where applicable, licensed, registered, and/or certified in their field.

4132.2D - Minimum Curriculum Requirements

(Rev. 1, 05-21-04)

The objective of NATCEPs is to enable nurse aides to provide quality services to residents. Therefore, a NATCEP must contain at least these minimum curriculum requirements for it to be approved. The State may also specify additional areas to be included.

Within the minimum 75 hours of training, at least 16 hours must be devoted to supervised practical training. Supervised practical training is defined as training in a laboratory or other setting in which the student demonstrates knowledge while performing tasks on an individual under the direct supervision of an RN or LPN. A program must also include at least 16 hours of classroom instruction prior to a trainee's direct involvement with a resident. This instruction must include the following:

- Communication and interpersonal skills;
- Infection control;
- Safety/emergency procedures, including the Heimlich maneuver;
- Promoting residents' independence; and
- Respecting residents' rights.

The curriculum must also include training in the following areas:

1. Basic nursing skills:
    a. Taking and recording vital signs;
    b. Measuring and recording height and weight;
    c. Caring for the residents' environment;

d. Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor. Some examples of abnormal changes are:

- Shortness of breath;
- Rapid respiration;
- Fever;
- Coughs;
- Chills;
- Pains in chest;
- Blue color to lips;
- Pain in abdomen;
- Nausea;
- Vomiting;
- Drowsiness;
- Excessive thirst;
- Sweating;
- Pus;
- Blood or sediment in urine;
- Difficulty urinating;
- Frequent urination in small amounts;
- Pain or burning on urination; and
- Urine has` dark color or strong odor.

e. Caring for residents when death is imminent.

2. Personal care skills:

    a. Bathing;

    b. Grooming, including mouth care;

    c. Dressing;

    d. Toileting;

    e. Assisting with eating and hydration;

    f. Proper feeding techniques;

    g. Skin-care; and

    h. Transfers, positioning, and turning.

3. Mental health and social service needs:

    a. Modifying aide's behavior in response to resident's behavior;

    b. Awareness of developmental tasks associated with the aging process;

    c. How to respond to resident behavior;

    d. Allowing residents to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity; and

    e. Utilizing resident's family as a source of emotional support.

4. Care of cognitively impaired residents:

    a. Techniques for addressing the unique needs and behaviors of individuals with dementia (Alzheimer's and others);

    b. Communicating with cognitively impaired residents;

    c. Understanding the behavior of cognitively impaired residents;

    d. Appropriate responses to the behavior of cognitively impaired residents; and

    e. Methods of reducing the effects of cognitive impairments.

5. Basic Restorative Services - The nurse aide should be able to demonstrate skills which incorporate principles of restorative nursing, including:

    a. Training the resident in self-care according to the resident's abilities;

    b. The use of assistive devices in transferring, ambulation, eating, and dressing;

    c. Maintenance of range of motion;

    d. Proper turning and positioning both in bed and chair;

    e. Bowel and bladder training; and

    f. Care and use of prosthetic and orthotic devices.

6. Residents' Rights - The nurse aide should be able to demonstrate behavior that maintains residents' rights, including but not limited to:

    a. Providing privacy and maintenance of confidentiality;

    b. Promoting the resident's right to make personal choices to accommodate their needs;

    c. Giving assistance in resolving grievances and disputes;

    d. Providing needed assistance in getting to and participating in resident and family groups and other activities;

    e. Maintaining care and security of resident's personal possessions;

    f. Providing care which maintains the resident free from abuse, mistreatment, and neglect, and reporting any instances of such treatment to appropriate facility staff; and

    g. Avoiding the need for restraints in accordance with current professional standards.

4132.2E - Competency Evaluation Component

(Rev. 1, 05-21-04)

All NATCEPs must contain competency evaluation procedures that meet the requirements specified in §4132.3.

4132.2F - Prohibition of Charges

(Rev. 1, 05-21-04)

No nurse aide who is employed by, or who has an offer of employment from, a facility on the date on which the aide begins a NATCEP may be charged for any portion of the program (including any fees for textbooks or other required course materials). If an individual who is not employed or does not have an offer to be employed as a nurse aide becomes employed by or receives an offer of employment from a facility not later than 12 months after completing a NATCEP, the State must provide payment for costs incurred in completing the program on a pro rata basis during the period in which the individual is employed as a nurse aide.

4132.3 - Requirements for CEP

(Rev. 1, 05-21-04)

4132.3A - Notification to Individual

(Rev. 1, 05-21-04)

The State provides advance notice to any individual who takes the competency evaluation that a record of the successful completion of the evaluation will be included in the nurse aide registry (NAR).

4132.3B - Content of CEP

(Rev. 1, 05-21-04)

Competency evaluations must consist of two components: a written or oral examination and a skills demonstration program. The written or oral examination must:

- Allow aides to choose between a written and an oral examination;
- Address each item specified in §4132.2.D;
- Be developed from a pool of test questions, only a portion of which is used in any one examination;
- Use a system that prevents disclosure of both the test questions and the individual competency evaluations; and
- If oral, must be read from a prepared text in a neutral manner.

The skills demonstration must consist of a demonstration of randomly-selected items drawn from a pool consisting of tasks generally performed by nurse aides. This pool of skills must include all of the personal care skills listed in §4132.2.D.

4132.3C - Administration of NACEP

(Rev. 1, 05-21-04)

The competency evaluation may be administered and evaluated only by:

- The State directly; or
- A State-approved entity which is not the SNF which provided the training.

The skills demonstration component of the evaluation must be:

- Performed in a facility or laboratory setting similar to the setting in which the individual functions as a nurse aide; and
- Administered and evaluated by an RN with at least one year's experience in providing care for the elderly or the chronically ill of any age.

4132.3D - Proctoring

(Rev. 1, 05-21-04)

The competency evaluation may, at the nurse aide's option, be conducted at the facility in which the nurse aide is or will be employed unless the facility is described in §4132.1.C.

The State may permit the competency evaluation to be proctored by facility personnel if it finds that the procedure adopted by the facility assures that the NATCEP:

- Is secure from tampering;
- Is standardized and scored by a testing, educational, or other organization approved by the State; and
- Requires no scoring by facility personnel.

The State retracts the right to proctor nurse aide competency evaluations from facilities in which it finds any evidence of impropriety or tampering by facility staff.

4132.3E - Successful Completion of CEP

(Rev. 1, 05-21-04)

The State establishes a standard for successful completion of the competency evaluation. To complete the competency evaluation successfully, an individual must pass both the written or oral examination and the skills demonstration. A record of successful completion of the competency evaluation must be included in the NAR described in §4141 within 30 days of the date the individual is found to be competent.

4132.3F - Unsuccessful Completion of Competency Evaluation

(Rev. 1, 05-21-04)

If an individual does not complete the evaluation satisfactorily, the individual must be advised:

- Of the areas in which he or she did not pass; and
- That he or she has at least three opportunities to take the evaluation.

The State may impose a maximum on the number of times an individual may attempt to complete the competency evaluation successfully, but the maximum may be no less than three.

4140 - Guidance to States for Medicaid NF Remedies

(Rev. 1, 05-21-04)

(See also Chapter 7)

4140A - Background

(Rev. 1, 05-21-04)

Section 1919(h) of the Act requires the State Medicaid Agency (SMA) to establish, by statute or regulation, remedies for NFs that do not meet the requirements of participation. The State must design remedies to result in faster correction of deficiencies and ensure the health or safety of residents of NFs. The SMA imposes these remedies for those NFs that are not operated by the State or those found noncompliant by the CMS validation process. The SA sends recommendations to the SMA for remedies under SMA jurisdiction, and to the RO for remedies under RO jurisdiction.

4140B - Required State Remedies

(Rev. 1, 05-21-04)

The SMA specifies the criteria as to when and how each remedy is applied, the amounts of any fines, and the severity of each remedy. The SMA designs the procedures to minimize the time between identification of violations and final imposition of remedies. Denial of payment for new admissions, appointment of temporary management, and closure are remedies that may be imposed during the pending of any hearing.

The criteria for all remedies are to provide for incrementally more severe fines for repeated or uncorrected deficiencies. In determining what action to take, the SMA will consider the NF's compliance history, change of ownership, and the number and gravity of the deficiencies. The SMA may also specify additional remedies, as long as the SMA can demonstrate are as effective in deterring non-compliance and correcting deficiencies as those that follow:

The SMA will follow regular procedures to amend it's approved State plan to establish at least the following remedies:

4140C - Alternative Remedies

(Rev. 1, 05-21-04)

The SMA will include the specified remedies in subpart B in its approved State plan for any quarter beginning after October 1, 1989. However, the SMA may establish remedies alternative to the specified State remedies (except for the remedy of termination) if the SMA can demonstrate to the satisfaction of CMS that their alternative remedies are as effective in deterring noncompliance and correcting deficiencies as those under §1919 (h)(2)(A) of the Act. For example, the SMA may already have alternative remedies in place for the licensure program or for the Medicaid program under State law, such as:

- Civil or administrative fines (different from the specified OBRA remedy);
- Court-appointed receiver;
- Conditional/provisional licensing, probationary license, or license revocation; and
- Withholding of payments.

If the SMA has alternative remedies in place, it will summarize its past experience with alternative remedies, indicating that they are effective in deterring noncompliance and correcting deficiencies.

The SMA will provide the following types of documentation to indicate the effectiveness of its alternative remedies, such as:

- Procedures for implementing the remedies including explanations of what type of deficiencies trigger the remedies, a method or ranking the seriousness of violations and corresponding remedies, timing of remedies and appeals and specific rules designating responsibility for the violation and liability for the remedies;

- Identification of the agency responsible for ensuring imposition of the remedies and the amount of resources being devoted to this effort, including legal and other enforcement-related staff; and

- Method of evaluation and supporting data for alternative remedies that have proved to be effective in deterring noncompliance and correcting deficiencies including the number of facilities in evaluation and the rate of recidivism.

Alternatives to the specified remedies must be submitted under the established procedures for approval of State plan amendments.

4140D - Incentives for High Quality Care

(Rev. 1, 05-21-04)

In addition to the remedies specified under §1919(h)(2) of the Act, the SMA may establish in it's approved State plan a program to reward NFs that provide the highest quality care to Medicaid residents. The reward may be in the form of public recognition, incentive payments, or both.

The expenses incurred in carrying out such a program are considered expenses necessary for the proper and efficient administration of the State plan under Medicaid. (See §1903(a)(7) of the Act.)

If the SMA elects to use an incentive payment, the State plan amendment must define highest quality care, state the criteria to be met, and the measurements to be used in awarding an incentive payment. To be considered as "efficient" in the administration of the State plan, the incentive payment must be reasonable, as determined by the RO in its State plan review process.

4140E - Federal Financial Participation (FFP)

(Rev. 1, 05-21-04)

Reasonable State expenditures for the proper and efficient administration of the State plan, such as temporary management, closing a NF, transfer of residents to another NF,

and other expenses associated with implementing these remedies, are subject to Federal matching payment at the rate of 50 percent. The SMA establishes procedures to prevent claiming FFP for expenditures which have been funded by the CMPs discussed in subpart B.

4141 – Nurse Aide Registry (NAR)

(Rev. 1, 05-21-04)

The State establishes and maintains a NAR of individuals who have successfully completed a NATCEP or CEP approved by the State, **or** are deemed to have completed a NATCEP, **or** have had the competency evaluation requirement waived. (See §4131.)

4141A - Registry Function

The State ensures that the NAR:

- Lists all individuals who have successfully completed a NATCEP or CEP approved by the State;
- Lists all individuals who are deemed to have completed a NATCEP;
- Lists all individuals for whom the requirement to complete a CEP has been waived by the State;
- Lists all nurse aides who are found by the State to have abused or neglected a resident or misappropriated resident property;
- Removes entries for all individuals who have performed no nursing or nursing-related services for monetary compensation for a period of 24 consecutive months, **except** those individuals who are found to have abused or neglected residents or misappropriated resident property;
- Discloses to everyone requesting information about an individual on the registry, the date of eligibility for placement on the registry, **and** any information pertaining to a finding of resident abuse or neglect, or misappropriation of resident property. (The State may disclose any additional information it deems necessary.);
- Provides individuals on the registry with all information in the registry on them when findings of resident abuse or neglect or misappropriation of resident property are made, or upon request;
- Permits all individuals on the registry sufficient opportunity to correct any misstatements or inaccuracies contained in the registry;

- Is sufficiently accessible to meet the needs of the public and health care providers;

- Provides requested information promptly; and

- Does not impose any charges related to registration on individuals listed in the registry.

The NAR may include information on home health aides who have successfully completed a home health aide training and competency evaluation program approved by the State **if** home health aides are differentiated from nurse aides.

4141B - Registry Information

(Rev. 1, 05-21-04)

The following items must be maintained and retrievable from the NAR for each individual who has completed a NATCEP or CEP approved by the State, who has been deemed to have completed a NATCEP, or for whom the State has waived the competency evaluation requirement:

1. The individual's full name;

2. Information necessary to identify the individual;

3. The date the individual became eligible for placement in the registry; and

4. Any finding by the SA of resident abuse or neglect or misappropriation of resident property by an individual documenting:

    - The SA investigation, including the nature of the allegation and the evidence that led it to conclude that the allegation was valid;

    - The date of the hearing (if the individual chose to have one) and its outcome; and

    - A statement disputing the allegation, if the individual chose to make one.

Findings of resident abuse or neglect or misappropriation of resident property against a nurse aide must be included in the registry within 10 working days of the finding and must remain in the registry permanently, unless the finding was made in error, the individual was found not guilty in a court of law, or the State is notified of the individual's death.

4141C - Responsibility for NAR

(Rev. 1, 05-21-04)

The State may contract the daily operation and maintenance of the registry to a non-State entity. However, the State must maintain overall accountability for operation of the registry and compliance with regulations, **and** only the SA is permitted to place findings of resident abuse or neglect or misappropriation of resident property on the registry.

4145 - Specification of Resident Assessment Instruments (RAIs) for Use in Long Term Care Facilities

(Rev. 1, 05-21-04)

4145.1 - Statutory Requirements

(Rev. 1, 05-21-04)

Sections 1819(b)(3), 1819(e)(5), 1819(f)(6)(B), 1919(b)(3), 1919(e)(5), and 1919(f)(6)(B) of the Act specify assessment requirements for SNFs for Medicare and NFs for Medicaid, which provide nursing, medical, and rehabilitative care to Medicare and/or Medicaid beneficiaries. These provisions require facilities to conduct comprehensive, accurate, standardized, and reproducible assessments of each resident's functional capacity using an RAI that has been specified by the State. Facilities are required to examine their residents no less frequently than once every three months.

These provisions place specific responsibilities on the Department of Health and Human Services, the State, and providers. The CMS is responsible for designating the minimum data set (MDS), common definitions and utilization guidelines, and for designating one or more RAIs for use by the States. The States are responsible for specifying the RAI for use by facilities in the State. The State may use an RAI designated by CMS or specify it's own instrument provided that it includes the MDS and that it has been approved by CMS. All State RAIs must include the MDS of core elements, common definitions and utilization guidelines specified by CMS. (See §4145.2.) Providers are responsible for using the specific assessment instrument that has been specified by the State and approved by the Secretary.

4145.2 - Definitions

(Rev. 1, 05-21-04)

- **Minimum Data Set (MDS)** - A core set of screening and assessment elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare and/or Medicaid. The items in the MDS

standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies.

- **Common Definitions** - Standardized instructions for how to interpret each element specified in the MDS.

- **Coding Categories** - Levels of measurement for each element included in the MDS.

- **Triggers** - Specific resident responses for one or a combination of MDS elements. These triggers identify residents who require further evaluation using resident assessment protocols designated within the State specified RAI.

- **Resident Assessment Protocols (RAPs)** - A component of the utilization guidelines, the RAPs are structured, problem-oriented frameworks for organizing MDS information, and additional clinically relevant information about an individual that identifies medical problems and forms the basis for individualized care planning.

- **Resident Assessment Instrument (RAI)** - An instrument which requires for completion the performance of a standardized assessment system, comprised of the MDS and utilization guidelines (including the RAPs and triggers). This assessment system provides a comprehensive, accurate, standardized, reproducible assessment of each long-term care facility resident's functional capabilities and identifies medical problems.

- **Utilization Guidelines** - Instructions concerning when and how to use the RAI. These include instructions for completion of the RAI as well as structured frameworks for synthesizing MDS and other clinical information.

- **Quarterly Review** - Part of the Secretary's designated instrument. The quarterly review is a subset of MDS items reviewed (i.e., reassessed) no less frequently than once every three months (92 days) to assure the continued accuracy of the care plan.

4145.3 - RAI by CMS

(Rev. 1, 05-21-04)

The CMS is responsible for designating the MDS, its common definitions and utilization guidelines, and for designating one or more RAI(s). The CMS' RAI is specified in Appendix R and is comprised of the utilization guidelines (including the RAPs), the MDS of core elements and common definitions, and the quarterly review items. The utilization guidelines for completion of the RAI are specified in Appendix R, Part I; the core elements of the MDS, common definitions, and quarterly review items are specified

in Part II; and the utilization guidelines pertaining to the RAPs, triggers and instructions are specified in Part III.

4145.4 - Specification of a State RAI

(Rev. 1, 05-21-04)

The State must specify an RAI for use in long term care facilities that participate in Medicare and/or Medicaid. The State must either specify:

- The RAI designated by CMS, which is comprised of the MDS with common definitions, the utilization guidelines, including CMS' RAPs, triggers and a documentation format (see Appendix R), and quarterly review items; or

- An alternate instrument for use in the State. An alternate instrument must be approved by CMS prior to the State specifying it to facilities. To receive approval, an alternate instrument must contain:

  a. **The Utilization Guidelines for Completion of the RAI** - See Appendix R, Part I.

  b. **The MDS** - See Appendix R, Part II. All data elements and corresponding coding categories specified in the MDS must be contained in the State's instrument. A State agency may not alter the MDS definitions or the coding categories used with each MDS element. The State may not rearrange the sequence of core MDS items or introduce new items within the core set of MDS items specified by CMS.

     - The State agency may add data elements additional to those in the MDS that are needed to meet unique State operational needs. Include these elements at the end of the core MDS in "Section S," which is designated for State supplemental items. These additional items will be reviewed by CMS to assure there is no conflict with elements included in the MDS. However, CMS will not evaluate the merits of those elements. Under the SNF Prospective Payment System (PPS) requirement, for residents in a Medicare part A covered stay, Section T must be completed with each MDS that is required for payment purposes. In addition, States may specify MDS sections T and/or U as part of the State-specified RAI.

     - **Discharge Tracking** - Includes section AA Items 1 - 9, (but only the three discharge codes from Item 8, Reasons for Assessment), Items AB1 - 2, A6, and R3 - 4. This form is completed when a resident dies or leaves the facility and is actually admitted to another health care facility, regardless of whether the long-term care facility formally

discharges the resident. (Refer to Appendix R for additional detail regarding the Discharge Tracking form and its use.)

- **Reentry Tracking** - This form contains Section AA Items 1 - 9, (but only one Reentry code from Item 8, Reasons for Assessment), and Items A4 and 6. This form is completed whenever a resident reenters the nursing home following temporary admission to a hospital or other health care setting, even if the resident's clinical record was not formally closed, and regardless of whether the resident was formally discharged from the facility. (Refer to Appendix R for additional detail regarding the Reentry Tracking form and its use.)

c. Utilization Guidelines Pertaining to the RAPs – At a minimum, State's RAI must include CMS' RAPs. As CMS develops new RAPs or revises RAP triggers or guidelines, a State agency must develop comparable changes.

To develop a new RAP, provide the following documentation to CMS when requesting approval to add the RAP to the State-specified RAI:

- Assessment triggers, based on MDS elements or other information requirements that screen which residents are subject to additional assessment;

- Guidelines, which provide a framework for additional assessment or structured investigation of issues to facilitate clinical decision-making for care planning; and

- Supporting documentation for clinical validation of RAP content (e.g., literature citations, expert consensus, research studies, results of field testing).

- States wishing to pursue RAP development are encouraged to seek consultation and assistance from CMS during the planning phase. Additionally, States are encouraged to volunteer to participate in CMS-sponsored RAP development/revision activities.

d. RAP Summary Form - Information from Section V of the MDS is documented on the RAP Summary Form. Each State's RAI must include CMS' RAP Summary Form or another standardized format for documentation of the RAP assessment. States may request approval of an alternate format for inclusion in the State RAI which:

- Identifies the location of information derived from RAPs about the resident's status in the triggered area. As appropriate for the resident, information may include the nature of problems, complications and risk factors, the need for referral to appropriate health professionals,

and the reasons for deciding to proceed or not to proceed with care planning specific to the triggered problems;

- Provides a means for collecting data on triggered RAPs and care plan decisions; and

- Provides a method for staff to certify the accuracy and completeness of the RAP assessment (i.e., signature and date).

e. Quarterly Review – States must specify a Quarterly assessment form, for use by facilities that include at least the items on the CMS-designated form (See Section R). The Quarterly assessment form contains the mandated subset of MDS items from Section A (Identification and Background Information) through Section R (Assessment Information) that serve as the minimum requirement within each State's RAI. Some States have mandated an expanded Optional Quarterly assessment form. The CMS has published two optional versions that States may require. A State may also require a full assessment on a quarterly basis. Contract your state RAI coordinator for State specifics. States have the following options for the Quarterly Assessment:

- Minimum Required MDS Quarterly Assessment;

- MDS Quarterly Assessment Form Optional Version for RIG-III;

- Full MDS Assessment;

- Medicare Prospective Payment Assessment Form (MPAF).

The State may require facilities to use the full MDS or may add MDS elements to the quarterly review but may not omit or reorder any elements in CMS' designated form. States may add items to their quarterly review form in one of two ways:

- Items that are part of CMS' MDS should be added within the same area of the quarterly review form that it falls on the full MDS (e.g., the State would add item H4, Change in Urinary Continence, after item H3 on the quarterly review form); or

- Items that are part of the State supplement (i.e., MDS Section S) should be added at the end of the State quarterly review form.

4145.5 - Variations in Formatting the State-Specified RAI

(Rev. 1, 05-21-04)

The CMS' approval of a State-specified RAI covers those items included on the instrument, the working and sequence of those items, and all definitions and instructions

for the RAI. Approval of the State-specified instrument does not address the attributes of the instrument related to formatting (for example, print type, color coding, or changes, such as integrating triggers into the instrument). States are encouraged to permit some flexibility in form design (e.g., print type, color, shading, or integrated triggers) or through use of a computer-generated printout of the RAI. The CMS' approval is not required for a State to permit such formatting variations. However, a State must assure that any RAI form or printout in the resident's record accurately and completely represents the State-specified RAI as approved by CMS, in accordance with 42 CFR 483.20(b). In other words, it includes all and only the items on the State-specified instrument with the exact wording and in the same sequence.

4145.6 - Approval Process

(Rev. 1, 05-21-04)

A State agency must not revise its specified RAI without first notifying CMS and receiving CMS' approval. All State agencies must adopt any revisions to the RAI that are specified by CMS.

All State agencies must inform CMS whether they intend to specify the RAI designed by CMS, or request approval for an alternative State instrument.

When specifying CMS' instrument, a State agency must include the following in its letter to CMS:

- A plan for implementation that includes time frames (e.g., effective dates) and plans for training the facilities; and

- The name, address, phone number, and e-mail address (if known) of the State RAI coordinator (i.e., the individual responsible for liaison and training of providers and State agency staff).

When requesting approval for an alternative instrument, or modifications to an existing specified instrument, a State agency must include the following in its request to CMS:

- A copy of the proposed instrument and any instructions that exceed CMS' utilization guidelines;

- A short narrative specifying how the instrument conforms with CMS' designated MDS and utilization guidelines (including the RAPs);

- A description of the items and their definitions that will appear in the State supplement section of the MDS;

- A plan for implementation that includes time frames and plans for training the facilities;

- The name, address, phone number, and e-mail address (if known) of the State RAI coordinator (i.e., the individual responsible for liaison and training of providers and State agency staff); and

- The name, address, phone number, and e-mail address (if known) of the State agency's contact for technical questions on the proposed alternate instrument.

Please send all correspondence to:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
Survey and Certification Group
Technical Director, Division of Nursing Homes
7500 Security Boulevard
Mail Stop S2-12-25
Baltimore, Maryland 21244

Once CMS has received a State agency's request for use of an alternate instrument, or modifications to an existing specified instrument, CMS will review the proposed instrument to determine whether it is an acceptable alternate, and will communicate directly with the State agency's representatives to clarify information, if necessary. The CMS will work with the State agency to meet its needs for resident assessment information.

Once a State agency has received approval from CMS for the alternate instrument, the State agency must implement the approved alternate. Within 60 days of receiving CMS' approval of the alternate RAI, the State agency must notify all long term care facilities participating in the Medicare and/or Medicaid programs in its State of the alternate instrument. This notification must include a copy of the approved specified instrument and the procedures for using the instrument.

States that have specified the CMS-designated RAI as their specified instrument must notify all long-term care facilities participating in the Medicare and/or Medicaid programs in their States of the specified instrument and any updates issued by CMS, with sufficient time for the facilities to meet the effective implementation date.

The State agency must ensure that all long-term care facilities participating in the Medicare and/or Medicaid programs in its State are using specified instrument within 90 days after a State agency has notified its providers of the specified instrument. To ensure that facilities are properly trained, each State agency must provide periodic educational programs for facility staff to assist with implementation of the specified RAI.

4146 - Minimum Data Set (MDS) System

(Rev. 1, 05-21-04)

The MDS system in each State is the cornerstone for a comprehensive, Quality Improvement and Evaluation System (QIES) that will not only fulfill MDS administration requirements, but also support other assessment-based programs (such as the Outcome and Assessment Information Set (OASIS) for home health agencies (HHAs), quality and performance indicators; and new, integrated survey and certification data systems. The State must use the MDS system for editing, storing, and processing MDS data to support CMS' MDS operating requirements within the State and to transmit the required MDS data to the CMS MDS repository. The State may not add additional software applications to the MDS system without a specific directive from CMS.

The automated MDS system is a critical component of State agency and CMS operations, and provides the means for transmission of assessment data to CMS for validating payments under the Medicare SNF Prospective Payment System (SNF PPS) for nursing homes.

The initial phase of the MDS system implementation involved a CMS-funded installation of standardized computer hardware and data management software at each State Agency to allow electronic transfer of MDS data elements from all Medicare and Medicaid nursing homes to the State. The data management software:

1. Validates the basic accuracy of the data and rejects submission files (batches) with **Fatal File Errors**, such as a missing or invalid Facility ID, incorrect record length, or missing headers or trailers;

2. Validates individual assessment records and rejects those records with **Fatal Record Errors**,

3. Stores and reports **Non-Fatal Errors** on records that are accepted by the database; and

4. Builds a database of MDS information for all residents in each nursing home in the State.

The MDS system implemented electronic transmission of MDS data by all Medicare and Medicaid nursing homes beginning with the regulation's effective date of June 22, 1998. This provides for enhanced analytical capabilities at the State agencies; electronic transmission from the State databases to a national repository; integration with performance indicators for quality oversight and survey planning by the State Agency; use of MDS data as a basis for prospective payment of nursing homes; research directed at improving quality of care; feedback to providers; and dissemination of information to purchasers, beneficiaries, and others.

The following procedures describe MDS system operations.

4146.1 - System Description

(Rev. 1, 05-21-04)

The CMS has provided each State with an MDS system composed of standardized hardware and software platforms scaled to meet each State's anticipated processing volumes. The hardware is comprised of a communications server, database server, modems and other peripheral devices. The QIES system software includes an Oracle database, Netscape Enterprise Server, Netscape Personal Edition, Microsoft Windows NT, the MDS/OASIS Data Management Application, and all required software licenses. The MDS system deployed to each State was specifically engineered and purchased to fulfill the MDS requirements of 42 CFR 483.20(f) and 483.315(h), additional CMS provider assessment processes as they become effective, and operational support of Medicare and Medicaid survey and certification pursuant to §1864 of the Social Security Act. The system was designed with an emphasis on flexibility and integration, so that additional software components could be easily added to provide the States with new MDS-related functionality (such as new or revised quality indicators and expanded analytical reports), as well as applications that support future assessment processes for other provider types, and new capabilities to support survey and certification operations or any other entity using the MDS data or system. Since each State's system was specifically sized to accommodate these planned functions, the SA or any other entity using the MDS data or system must not add other, non-CMS prescribed, applications or databases to the MDS system.

4146.2 - Administration Requirements

(Rev. 1, 05-21-04)

The States are directly responsible for fulfilling requirements to operate the State MDS system. However, the State may enter into an agreement with the SMA, another State component, or a private contractor to perform day-to-day operations of the system.

The State must obtain RO approval prior to entering an agreement with another agency**.** Criteria for approval are provided at Exhibit 259. Under any such arrangement, the State must be guaranteed real-time, priority access to this system to fully support all MDS functions specified in the MDS procedures and this manual. All CMS privacy and confidentiality requirements must be met. Off-site operation of the MDS system will require high capacity, fault-tolerant network connections to ensure reliable support for the State's daily operations that will be affected by this system. The State also must use the MDS system for reporting MDS data to the CMS central repository.

To promote national consistency in MDS system operations and troubleshooting, each State must designate one individual as the MDS automation project coordinator. This

person is CMS' key contact within each State for managing MDS system issues. This person must be familiar with the use of the RAI and the MDS automation and transmission process. Technical knowledge of information systems is useful but far less critical than an understanding of the RAI and MDS processes, good communications and project management skills, and the ability to educate and work with providers and vendors to ensure successful implementation of an automated process for all providers. The State should designate additional staff, including a system administrator to manage the technical aspects of running the MDS system, and support staff to assist in answering routine user questions, assigning passwords, etc.

With respect to systems maintenance, the MDS system installed in each State is comprised of commercial off-the-shelf hardware and software components that are generally covered under typical umbrella service agreements that the State may already have in place for maintenance of data processing equipment. Those MDS software components that are developed and distributed by CMS will be maintained and upgraded centrally by CMS. The State will not be responsible for these software upgrades.

To the extent that the State has developed customized external applications for using information obtained from the MDS database (e.g., to support Medicaid payment), the costs of developing and maintaining these additional software applications (and any related hardware components) will not be funded through the survey and certification budget.

4146.3 - Validation and Editing Process

(Rev. 1, 05-21-04)

Each time a facility accesses the State MDS system and transmits an assessment file, the State system performs a series of three levels of validations:

1. **Fatal File Errors -** The first check examines the basic structure and integrity of the submission file. If there are fatal flaws in the file (batch of records), the entire file is rejected and the facility is notified of the reason for rejection in the "Initial Feedback Report." In the event that a batch is rejected due to **Fatal File Errors**, the facility will not receive a "Final Validation Report." Rejected files must be corrected and retransmitted. **Fatal File Errors** are described in a document named spdoc110.pdf, that is posted at the CMS website, http://www.cms.hhs.gov/medicaid/mds20/ under "MDS Software and Data Specifications" and then under "Version 1.10 Files Available for Downloading." The spdoc.pdf document is in a "zip" file names MDS 110.zip.

2. **Fatal Record Errors** - If the file structure is acceptable, then each MDS record in the file is examined individually for **Fatal Record Errors**. These errors include out of range responses (this edit applies to most, but not all fields), selected inconsistent relationships between fields, or errors which made identifying a resident or record type difficult. Fatal Record Errors result in

rejection of individual records by the State MDS database. The facility is informed of **Fatal Record Errors** on both the "Initial Feedback Report" and the "Final Validation Report." An overview of **Fatal Record Errors** is provided in a document called spdoc110.pdf, available in a "zip" file names mds 110.zip at http://www.cms.hhs.gov/medicaid/mds20 under "MDS Software and Data Specification" and then under "Version 1.10 Files Available for Downloading." A detailed listing of **Fatal Record Errors** is provided in the item-by-item MDS record specifications, Document names d_dt120.pdf, available in a "zip" file names mds 120.zip at http://www.cms.hhs.gov/medicaid/mds20 under "MDS Software and Data Specifications" and then under "Data Specifications Version 1.20 for the QIES MDS July 2002 Release." One additional Fatal Record Error is based on the submission requirement under which the MDS record is submitted by the facility. There is a data field called SUB_REQ that deals with this issue. **Fatal Record Errors** based upon the SUB_REQ field are described in a special document named subreqspecs.pdf at http://www.cms.hhs.gov/medicaid/mds20 under "MDS Software and Data Specifications" and then under Data Specifications and Instructions for the QIES MDS November 26, 2001 Release." At this level of validation, the MDS standard system at the State is designed to reject individual records with **Fatal Record Errors** and to accept records with no **Fatal Record Errors**. An electronic "final validation report" is made available to the facility and includes error messages for individual records found to have errors, and a statement of record status (accepted or rejected), with associated error statements for any rejected records. Rejected records must be corrected and retransmitted.

3. **Non-Fatal Errors** - If there are no **Fatal Record Errors**, the record is loaded into the State database and the record is further examined for **Non-Fatal Errors**. Any **Non-Fatal Errors** are reported to the facility in the "Final Validation Report." **Non-Fatal Errors** include missing or questionable data of a non-critical nature, field consistency errors of a non-critical nature, and record sequencing and timing errors.

The Initial Feedback Report is available for the facility to download immediately following the submission of a file. Since the Final Validation Report will not be available as quickly as the Initial Feedback Report, the facility may, based on experience, choose to obtain this report on a subsequent logon.

The validations and edits described above fulfill all of CMS' editing requirements under 42 CFR 483.315(h)(1)(iv). Also, as specified at 42 CFR 483.315(h)(2)(ii), States or other data/system users may not modify any aspect of the CMS MDS standard system, including these validations and edits, the Standard Record Layout, and the software code and specifications on which the system is based.

States that use MDS data for Medicaid payment may require additional assessment information not required by CMS' MDS system. Section S (the State-specific section) of the MDS system was designed for this purpose. Moreover, some States may impose

additional edits on Medicaid assessments. However, a State or other data system users may not interfere with, modify, or delay the transmission of records, meeting CMS edit standards, from a Medicare and/or Medicaid certified facility to the CMS MDS standard system.

Furthermore, the State or other data system users may not impose any requirements that modify the clinical accuracy of CMS prescribed MDS records, reports, or calculations.

4146.4 - Reports

(Rev. 1, 05-21-04)

The MDS system provides the following reports to both the State and the provider. These reports, which focus on errors in MDS submissions, are key to working with facilities to ensure successful transmission of MDS data.

1 - Initial Feedback Report

During a submission session, the facility will be informed of file submission status in an Initial Feedback Report. The Initial Feedback Report may indicate that the batch was "accepted," "received" (for a test file), or that it was "rejected." Since the Initial Feedback Report is not automatically saved by the system, it must be reviewed prior to logging off after a batch submission.

The top section of this report gives general information about the entire batch of records.

- Report Date/Time;

- Batch Status - Status is "Rejected" if a file had **Fatal File Errors** and the entire batch of records was rejected. Status is "Accepted" if a file had **no Fatal File Errors** and individual records were processed for loading into the State database. For **test** files only, status is "Received" if the test submission had no **Fatal File Errors**. Test records are not inserted in the database;

- Submission Date/Time - Date/time that the MDS file was submitted; may be needed for troubleshooting any problems with a batch;

- Submission Batch ID - Unique ID assigned to each batch used for troubleshooting problems with a batch;

- Facility ID - The standard system logon ID for the facility;

- Facility Name;

- Number of Records Processed - Number of data records in the file (batch)--value will be 0 if the entire file is rejected;

- Number of Records Rejected - Number of data records that contained **Fatal Record Errors** and were not accepted into the State database. If the entire file was not **rejected**, this value will be 0 on the Initial Feedback Report. This value and the Report Detail will be provided in the Final Validation Report upon validation of all records in the file;

- Number of Records with Errors - Number of records that were accepted into the State database but that also contained **Non-Fatal Errors**. If the entire file was not **rejected**, this value will be 0 on the Initial Feedback Report. This value and the Report Detail will be provided in the Final Validation Report upon validation of all records in the file; and

- Total Number of Errors - Total number of **Non-Fatal Errors** across all records accepted into the State database. If the entire file was not **rejected**, this value will be 0 on the Initial Feedback Report. This value and the Report Detail will be provided in the Final Validation Report upon validation of all records in the file.

Detail concerning any file header and trailer errors will appear in the lower portion of the Initial Feedback Report, under "Report Detail." The Report Detail section includes the following information (clarification of labels is given in parentheses):

- Record Type, Effective Date - The record type field can contain "Header" for a header record, "Trailer" for a trailer record;

- Field - Field in error;

- Invalid Data - Data that caused the error; and

- Error Description - Descriptive error message.

2 - Final Validation Report

If there are **Fatal File Errors** with the MDS submission file, the entire batch of records is rejected and the only feedback that the facility will receive during the submission session is the Initial Feedback Report. However, if there are no **Fatal File Errors**, a Final Validation Report will also be received by the facility. The Final Validation Report has exactly the same layout as the Initial Feedback Report. The "Report Detail" section of the Final Validation Report details all errors found in the data records in the batch. These errors can be **Fatal Record Errors** (resulting in record rejection) or **Non-Fatal Errors**. The following information is displayed in the record detail section:

- SSN, Name - Resident SSN and name;

- Record Type, Effective Date - The Record Type field contains "Header" for a header record, and "Trailer" for a trailer record. For data records, the record type field contains the data record types as defined in definitions section (e.g., "A" for an initial admission assessment record, "Q" for a quarterly update assessment, etc.). For a data record, the Effective Date for the record follows the record type. The effective date A4a for a reentry record R2b for an assessment record, and R4 for a discharge record.

- Target Date.- The target date field contains the date that the reentry, assessment or discharge event occurred. The target date is A4a for a reentry record. A3a for an assessment record, and R4 for a discharge record.

- Field or MDS Items. - Field or fields in error. A single field or item will be present for data range or formatting errors. Two fields will be present for errors involving required consistency between pairs of MDS items.

- Invalid Data Submitted - Data values that caused the error. There will be single value for errors involving data range or formatting errors. Two values will be present involving consistency between pairs of MDS items.

- Message Number.- The system numeric code for the error detected. The numeric codes are negative numbers. After the numeric code the report indicates if the error is "Fatal" or Non-Fatal."

- Message. - Descriptive error message.

The additional reports listed below are available to the State for the MDS system, but not directly to the provider. The State may provide copies of these reports to the facilities as they deem appropriate.

- **Assessment Field Information -** Displays information about each assessment field in the database including field name, start position, field length, valid values, start and end ranges (for numeric fields), field data type, field description, and which assessment section contains the field;

- **Assessment Primary Reason -** (MDS Item A8a or AA8a) - Displays information about primary reason for assessment;

- **Assessment Sections** - Displays which assessment sections are included for each combination of Primary Reason for Assessment (MDS Item A8a or AA8a) and Special Reason for Assessment (MDS Item AA8b) values;

- **Assessment Special Reason -** (MDS Item A8b or AA8b) - Displays information about these values;

- **Case Mix Codes -** Displays details of each CMI set that is in the database. Information includes CMI sequence, set name, ADL values, CMI codes, CMI values, and descriptions;

- **Discharges in Previous Month** - A list of residents who had discharge assessments (as the last assessment) submitted in the last 30 days. Report can be generated for a single facility or all facilities;

- **Duplicate Resident Names** - A list of residents with identical first and last names. Useful for finding duplicate residents in a facility;

- **Duplicate Resident SSN** - A list of residents who are listed as having the same SSN. All residents for a particular SSN are listed. This report is also useful for finding duplicate residents;

- **Error Summary -** This report lists the errors that have occurred in submissions, the number of occurrences, and the percentage of assessments with each error. The report is for a single facility, all facilities, for a single vendor, all vendors, or for an entire State for a specified time period;

- **Error Message** - Displays all of the error message codes and descriptions;

- **Error Detail -** List of all errors for all submissions grouped by assessment. The report can be generated for a single facility, all facilities, a single vendor, or all vendors for a specified time period;

- **Errors by Field** - Lists, by field, the number of assessments that had an error in that field, the number of assessments successfully processed, and the percentage of assessments with each error. Can be generated for a single facility, all facilities, a single vendor, all vendors, or the entire State for a specified period of time**;**

- **Facility Accounts Report -** Lists all facilities and their logon ID and password;

- **Facility List** - Listing of all facilities in a State that submit MDS assessments;

- **Facility List, No Recent Submissions** - Listing of all facilities in the State that have not submitted assessments since a specified date;

- **Facility List - Non-Submitted Data** - Listing of all facilities that have not submitted assessments;

- **Overdue Assessments -** Listing of all residents who have not had assessments submitted within the required timeframe. Report includes which assessment type(s) is/are expected. Available for a single facility or all facilities;

- **Quarterly Assessment Fields -** Listing of all fields that are included for each quarterly assessment type grouped by each MDS Item AA8a/AA8b combination;

- **Roster Report -** Lists all residents who are currently in a facility. Can be generated for a single facility or all facilities;

- **Roster Timeframe Report -** List all residents who are in a facility within a specified date range. Can be generated for a single facility or for all facilities;

- **Sequencing Report -** Displays invalid sequences between assessments. Displayed by two sets of MDS Item A8a/A8b or AA8a/AA8b combinations and Record Types (current and previous);

- **State Customization -** List the values for the active CMI set for the State, State optional fields (if any), and the validation engine options set by the State;

- **Summary Statistics -** List the number of files received, number of records processed (by record type), number of records rejected, and number of records received with errors (by record type). Available for a single facility or all facilities for a specified time period;

- **Validation Codes -** A reference report that lists valid codes for various fields in the assessment;

- **Vendor List -** A list of facilities that have used a particular vendor. This report can be generated for a single vendor or multiple vendors; and

- **Ad Hoc Reports -** Various user-defined reports can also be generated using structured query language within the Data Management Application.

In addition, the MDS system has made other reports available to both the States and providers, based on the deployment of analytical and quality indicator software.

4146.5 - Correction of Errors in MDS Records That Have Been Accepted by the Standard MDS System at the State

(Rev. 1, 05-21-04)

The standard MDS system in each State includes a mechanism by which facilities can electronically submit corrections to MDS data that have already been accepted into the State MDS database. Depending on the circumstances surrounding the error, corrections

may include modification or inactivation of MDS records (assessments, Discharge Tracking forms and Reentry tracking forms). The MDS system provides management reports to the State that analyze the type, nature and frequency of corrections submitted by facilities to the MDS database at the State. For information about the process of correcting errors in MDS records in the State database, refer to "Correction Policy for MDS Records" in Appendix R, Part IV.

4146.6 - Replication to the CMS Repository

(Rev. 1, 05-21-04)

Each State's MDS database will be transmitted to CMS' Central Repository at least monthly using a data replication process initiated by CMS. Since the process will be managed by CMS through an automatic polling process, the States will not actually have to transmit the data. However, the State must ensure that the CMS data-line established for this purpose is accessible to CMS at all times for testing and monitoring purposes. Actual replication access to the Oracle assessment data tables may be controlled by the States but, in such cases, a fixed schedule must be established with CMS Central Office.

The MDS system and CMS data line meet all industry security standards. However, if the State is concerned about security, it may establish a firewall (an electronic block) to restrict access to the State's portion of the network. Access must not be restricted to the CMS-supplied MDS System.

4146.7 - Privacy and Confidentiality

(Rev. 1, 05-21-04)

4146.7A - System of Records

(Rev. 1, 05-21-04)

The MDS database is operated and maintained by States as a Federal database and, as such, is subject to the requirements of the Federal Privacy Act. The text of the System of Records notice for the MDS, which follows, describes the legal requirements regarding privacy and disclosure of information by CMS or the State.

> The purpose of the Long Term Care Minimum Data Set (LTC MDS) System NO. 09-70-1517 is to aid in the administration of the survey and certification of Medicare/Medicaid long term care facilities and to study the effectiveness and quality of care given in those facilities. This system supports regulatory, reimbursement, policy and research functions. In addition, this system will enable Federal and State regulators to provide long term care facility staff with outcome data for provider's internal quality improvement activities.

This system shall contain clinical information found in the comprehensive assessments of persons residing in long term care facilities that are certified to participate in the Medicare and/or Medicaid programs (including private pay individuals). This information is found in the Long Term Care Minimum Data Set for Nursing Home Resident Assessment."

The CMS established this system in accordance with the principles and requirements of the Privacy Act. The Privacy Act allows the disclosure of information from this system without an individual's consent if the information is to be used for a purpose that is compatible with the purposes for which the information was collected. Any such compatible use of data is known as a "routine use." The proposed routine uses for this system meet the compatibility requirement of the Privacy Act since they are consistent with the purpose of analyzing data on the physical, mental, functional, and psychosocial status of nursing facility residents living in the State.

The routine uses specify the circumstances under which CMS and the State in their roles as contractors representing CMS may release information from the long-term care MDS system without the consent of the individual to whom such information pertains. The CMS System Manager must evaluate each proposed disclosure of information under the routine uses and/or an individual authorized by CMS. The authority to release data is limited to the System Manager or authorized designee.

4146.7B - Procedures for Disclosure of Information Pursuant to Data Use Agreement

(Rev. 1, 05-21-04)

Releases of information **must be** evaluated to determine if disclosure is **legally permissible** by the CMS System Manager or authorized designee, including but not limited to ensuring that the purpose of the disclosure is compatible with the purpose for which the information was collected. Releases are generally only made for the routine uses specified in the system notice. The CMS System Manager or authorized designee **must require** each prospective recipient of LTC MDS system information to agree in writing to certain conditions to ensure the continuing confidentiality and to physically safeguard of the information. For each disclosure it is necessary for the System Manager or authorized designee to, as necessary and appropriate:

1. Determine that no other Federal statute specifically prohibits disclosure of the information;

2. Determine that the use or disclosure does not violate legal limitations under which the information was provided, collected, or obtained;

3. Determine the purpose for which the disclosure is to be made:

    a. Cannot reasonably be accomplished unless the information is provided in individually identifiable form;

    b. Is of sufficient importance to warrant the effect on or the risk to the privacy of the individual(s) that additional exposure of the record(s) might bring;

    c. There is a reasonable probability that the purpose of the disclosure will be accomplished; and

    d. The purpose is within the scope of a routine use.

4. Require the recipient of the information to:

    a. Establish reasonable administrative, technical, and physical safeguards to prevent unauthorized access, use, or disclosure of the record or any part thereof. The physical safeguards shall provide a level of security that is at least equivalent to the level of security contemplated in OMB Circular No. A-130 (revised), Appendix III, Security of Federal Automated Information Systems, which sets forth guidelines for security plans for automated information systems in Federal agencies; contemplated in OMB Circular No. A-130 (revised), Appendix III, Security of Federal Automated Information Systems, which sets forth guidelines for security plans for automated information systems in Federal agencies;

    b. Remove or destroy the information that allows subject individual(s) to be identified at the earliest time at which removal or destruction can be accomplished, consistent with the purpose of the request;

    c. Refrain from using or disclosing the information for any purpose other than the stated purpose under which the information was disclosed; and

    d. Make no further use or disclosure of the information except:

        - To prevent or address an emergency directly affecting the health or safety of an individual;

        - For use on another project under the same conditions, provided the System Manager or authorized designee has authorized the additional use(s) in writing; or

        - When required by law.

5. Secure a written statement or agreement from the prospective recipient of the information whereby the prospective recipient attests to an understanding of, and willingness to abide by the foregoing provisions and any additional provisions that the System Manager deems appropriate in the particular circumstance. The System Manager or authorized designee must use a CMS-approved Data Release Agreement that cannot be modified; and

6. Determine whether the disclosure constitutes a computer "matching program" as defined in 5 U.S.C. §552a(a)(8). If the disclosure is determined to be a computer "matching program" the instructions regarding preparation and transmission of a matching agreement as stated in 5 U.S.C. §552a(o) must be followed.

4146.7C - Routine Uses

(Rev. 1, 05-21-04)

The following lists the routine uses published in the LTC MDS System NO. 09-70-1517 (current as of February 2002).

Disclosure may be made:

1. To Agency contractors, or consultants who have been engaged by the Agency to assist in accomplishment of a CMS function relating to the purposes for this system and who need to have access to the records in order to assist CMS;

2. To another Federal or state agency, agency of a state government, and agency established by state law, or its fiscal agent to:

    a. Contribute to the accuracy of CMS' proper payment of Medicare benefits;

    b. Enable such agency to administer a Federal health benefits program, or as necessary to enable such agency to fulfill a requirement of a Federal statute or regulation that implements a health benefit program funded in whole or in part with Federal funds, and/or;

    c. Assist Federal/state Medicaid programs within the state.

3. To QIOs in connection with review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XI of the Act and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans;

4. To insurance companies, underwriters, third parties administrators (TPA), employers, self-insurers, group health plans, health maintenance organizations (HMO), health and welfare benefit funds, managed care organizations, other

supplemental insurers, non-coordinating insurers, multiple employer trusts, liability insurers, no-fault medical automobile insurers, workers compensation carriers or plans, other groups providing protection against medical expenses without the beneficiary's authorization, and any entity having knowledge of the occurrence of any event affecting (a) an individual's right to any such benefit or payment, or (b) the initial right to any such benefit or payment, for the purpose of coordinating of benefits with Medicare program and implementation of MSP provision at 42 U.S.C. 1395y(b). Information to shall be limited to Medicare utilization data necessary to perform that specific function. In order to receive the information, they must agree to:

a. Certify that the individual about whom the information is being provided is one of its insured or employees, or is insured and/or employed by another entity for whom they serve as a TPA;

b. Utilize the information solely for the purpose of processing the individual's insurance claims; and

c. Safeguard the confidentiality of the data and prevent unauthorized access.

Other insurers may require LTCMDS information in order to support evaluations and monitoring of Medicare clams, information of beneficiaries, including proper reimbursement for services provided.

5. To an individual or organization for research, evaluation, or epidemiological projects related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects;

6. To a Member of Congress or congressional staff member in response to an inquiry of the congressional office made at the written request of the constituent about whom the record is maintained;

7. To the Department of Justice (DOJ), court or adjudicatory body when:

   a. The Agency or any component thereof;

   b. Any employee of the Agency in his or her official capacity;

   c. Any employee of the Agency in his or her individual capacity where the DOJ has agreed to represent the employee; or

   d. The United State Government, is a party to litigation or has an interest in such litigation, and by careful review, CMS determines that the records are both relevant and necessary to the litigation.

8. To a CMS contractor (including, but not limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such program;

9. To another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any state or local government agency), that administers, or that has the authority to investigate potential fraud or abuse in a health benefits program funded in whole or in part by Federal funds, when disclosure is deemed reasonably necessary by CMS to prevent, deter, discover, detect, investigate, examine, prosecute, sue with respect to, defend against, correct, remedy, or otherwise combat fraud or abuse in such programs. Other agencies may require LTCMDS information for the purpose of combating fraud and abuse in such Federally funded programs; and

10. To a national accrediting organization whose accredited facilities are presumed to meet certain Medicare requirements fro inpatient hospital (including swing beds) services; e.g., the Joint Commission for the Accrediting of Healthcare Organizations (JCAHO). Information will be released to accrediting organizations only for those facilities that they accredit and that participate in the Medicare program.

4146.7D - Access by an Individual to His or Her Own Records

(Rev. 1, 05-21-04)

Upon request by any individual with records contained in the system of records, the System Manager or authorized designee shall permit the individual to review his/her records and obtain a copy of all or any portion thereof (in a form comprehensible to the individual) unless an exemption under the Privacy Act applies. Fees may be charged only for the cost of copying the records, and not for time spent searching for the records or determining whether to release the records. The individual may have another person accompany him/her while reviewing the records, but must furnish a written statement authorizing disclosure and discussion of the records in the accompanying person's presence. The individual may request amendment of any portion of his/her records which is not accurate, relevant, timely or complete.

4146.7E - Criminal Penalties for Improper Disclosure

(Rev. 1, 05-21-04)

Under the Federal Privacy Act, the following criminal penalties may be applicable:

- Any officer or employee of the State who intentionally discloses individually identifiable information prohibited from disclosure under the Privacy Act, shall be guilty of a misdemeanor and fined not more than $5,000;

- Any officer or employee of the State who willfully maintains a system of records without meeting the notice requirements of the Privacy Act shall be guilty of a misdemeanor and fined not more than $5,000; and

- Any individual who knowingly and willfully requests or obtains any record concerning an individual from an agency under false pretenses shall be guilty of a misdemeanor and fined not more than $5,000.

4146.8 - System Security

(Rev. 1, 05-21-04)

As distinguished from confidentiality and privacy, which primarily focus on the rules for release on information when it is authorized, security relates to the means by which the information is protected from unauthorized access, disclosure and misuse. The State must ensure that the electronic data in the MDS system is protected to the same degree that paper records containing any identifiable data must be safeguarded. Additionally, any printed copies of reports from the system must be maintained in a secure locked area while they are needed and shredded when no longer needed.

The State must issue a policy that delimits the qualifications for an individual to access the MDS system and the system administrator must issue passwords and user IDs in strict adherence to those requirements. Those who receive passwords must be aware of the requirement of the State's security policies and those of the System of Records and the Privacy Act. The system administrator and those who have received passwords must protect passwords. Passwords must be disabled at the time an individual leaves a position requiring MDS system access.

No one should leave the MDS system in a logged-on status when leaving the area. If possible, the system hardware should be located in an enclosed area, with a door having interior hinges that can be locked. Keys or a combination should be available to only a minimal group of individuals with a need for access to the system.

In addition to the specific guidance above, the safeguards must provide a level of security at least equivalent to that required by the Office of Management and Budget Circular A-130 (revised) Appendix III, Security of Federal Automated Systems.

4146.9 - RO Roles and Responsibilities

(Rev. 1, 05-21-04)

ROs must provide the States with the program guidance and technical assistance critical to successful implementation of MDS and subsequent programs and ensure that the States have the necessary resources to accomplish these goals.

The following activities must be performed by the RO:

1. **Budget Process** - The RO must review each State agency's budget request and the required MDS Implementation Plans in accordance with the Budget Call Memorandum and reasonable and prudent expenditure of funds to ensure that States receive a fair and reasonable allocation. The RO must monitor Quarterly Expenditure Reports against the States' allocation;

2. **Review State Implementation Plans** - The RO must review all annual MDS Implementation Plans from the States and ensure that the States have reasonable plans for ensuring facilities have the technical information, training, and assistance they need to comply with MDS submission and accuracy, privacy and security requirements, and that the States are monitoring facility compliance with MDS requirements;

3. **Review Contracts and Agreements** - The RO must ensure that the State survey agency has executed an agreement with another entity if that other entity is operating the MDS system on behalf of the State survey agency responsible for nursing home survey and certification;

4. **Provide Training and Technical Assistance** - The RO must provide training and technical assistance to the States in MDS implementation requirements and continuing education in the MDS program;

5. **Perform Focused Reviews/Federal Surveys** - The RO will use the National MDS Repository assessment and quality indicator data to select facilities for focused reviews, and in preparation for Federal surveys; and

6. **Take Enforcement Action** - The RO will process and effectuate enforcement actions for non-compliance with MDS requirements.

4146.10 - Provider Relations

(Rev. 1, 05-21-04)

With CMS technical support and guidance, the States must work closely with the provider community and their MDS 2.0 software vendors in providing information on specific requirements related to the submission of MDS assessments to the State MDS system. The standardization of the State MDS system extends back to the provider because a common data communications software package is used by providers to transmit MDS assessments to the State.

The CMS expects that a facility's software vendor will provide primary support to the facility in terms of MDS encoding and transmission to the State repository. The State, however, must work with facilities and software vendors in educating them about this process and in working out some of the initial problems in getting provider data through the vendor software and into the State MDS system. The States must also provide training and technical assistance in interpretation of MDS reports provided to facilities. The State will also fund the monthly telephone line charges associated with transmission of the MDS data from the facilities to the State.

SA Analysis Activity

4149 - OSCAR System

(Rev. 1, 05-21-04)

4149A - Summary

(Rev. 1, 05-21-04)

The Online Survey Certification and Reporting System (OSCAR) collects provider and supplier certification information and generates reports which compile this information into a workable format. The SA has primary responsibility for entering all recertification and Medicaid initial survey data, except for nursing homes and home health agencies, into the Online Data Input and Edit (ODIE) subsystem of OSCAR via computer terminals. The RO is responsible for entering all Medicare initials and terminations unless this has been delegated to the SA. Nursing homes and home health agencies data must now be entered through ASPEN Central Office (ACO) by SAs and ASPEN Regional Office (ARO) for ROs. The data will move from ASPEN to OSCAR. Entered deficiency data is compared against a list of critical requirements (flags) in order to identify surveys that require submittal to the RO by the SA for substantive professional review prior to approval for continued program participation. After a compliance determination is made, additional information is entered into the system to complete the certification record. Standard reports are available from OSCAR and can be produced on an as-needed basis. User designed reports can be set up and saved in a user library for future use. Each standard and user designed report pertains to a particular aspect of the certification process. The intended use of these reports is to help SAs understand and manage their workload and identify processing problems for correction.

4149B - Availability of OSCAR Data

(Rev. 1, 05-21-04)

Provider information abstracted from the certification documents is maintained in OSCAR data records and produced in various formats to assist the SA, RO, and CO in managing and assessing their respective areas of responsibility in the certification process. It is the responsibility of each SA, the ROs, and CO to generate the reports necessary to monitor and manage their certification workload.

The SA/RO should generate OSCAR Report 2 (Facilities Scheduled for Survey) on a regular basis for those provider/supplier types currently being surveyed on an annual basis. They should obtain history profile of deficiencies for these facilities by running OSCAR Report 3 (Facility History Profile). Here, they can target their search on

Condition, standard, lesser requirements, or all deficiencies. Other OSCAR reports that would be useful to the SA, RO, or CO and can be generated on an as-needed basis are:

- OSCAR Report 9 (Average Certification Work Processing Times) which calculates the average processing times to complete the certification of each category of participating providers and suppliers;

- OSCAR Report 9R (Recap of Certification Work Processing Times) compares the average processing times by certification processing steps and type of certification action;

- OSCAR Reports 18 through 20 provide a Comparison of Deficiency Patterns by tag number sequence, by State, region, and frequency of occurrence. This information is displayed either by State, region, and nation; and

- OSCAR report 5 and 6 provide a listing of all Medicare/Medicaid facilities in alphabetical order by type of facility, chronological survey date order, zip code, or State region code.

Through the user defined features of OSCAR, users can customize and design their own reports as well as extract data and download that data to a PC where it can further be analyzed with the available PC tools.

OSCAR has on-line information retrieval. Its inquiry option provides the ability to search by name, provider number, provider type, or ZIP code.

4149C - Review of Certification Data

(Rev. 1, 05-21-04)

It is crucial that the SA and RO review all certification documents for completeness and accuracy prior to data entry to maintain the integrity of the OSCAR database. To avoid processing delays, make sure the appropriate forms, as listed below, are at hand. The ODIE and ACO systems are programmed to accept data from complete certification kits that contain all required forms. Some documents are common to all initial and recertification kits including the "Medicare/Medicaid Certification and Transmittal" (Form CMS-1539), the appropriate Request for Certification form, the "Statement of Deficiencies and Plan of Correction" (Form CMS-2567), and the Crucial Data Extract (CDE). The SA and RO may enter the data from the "Post-Certification Revisit Report" (Form CMS-2567B) detailing the status of the deficiencies on the revisit either at the time of initial data entry or, if the facility record is already in OSCAR, at a later time. The CDE must be present in every kit. The CDE for each type of institution corresponds to the respective Survey Report and abstracts certain compliance and deficiency information for data collection purposes.

The following list includes all the basic certification documents (including their provider number series that follows the 2-digit State code) required for ODIE or ASPEN Central Office input in all routine initial and recertification packages:
(See also §2779.)

1. **Nonaccredited Acute Hospital** (0001 to 0879)
    - "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
    - "Request to Establish Eligibility," Form CMS-1514
    - "Statement of Deficiencies and Plan of Correction," Form CMS-2567
    - Crucial Data Extract for Form CMS-2786
    - "Survey Team Composition and Workload Report," Form CMS-670
2. **Nonaccredited Psychiatric Hospital** (4000 to 4499)
    - "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
    - "Request to Establish Eligibility," Form CMS-1514
    - "Statement of Deficiencies and Plan of Correction," Form CMS-2567
    - Crucial Data Extracts for Form CMS-2786
    - "Survey Team Composition and Workload Report," Form CMS-670
3. **Accredited Acute Hospital** (0001 to 0879)
    - "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
    - "Request to Establish Eligibility," Form CMS-1514
4. **Accredited Psychiatric Hospital** (4000 to 4499)
    - "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
    - "Request to Establish Eligibility," Form CMS-1514
    - "Statement of Deficiencies and Plan of Correction," Form CMS-2567
    - "Survey Team Composition and Workload Report," Form CMS-670

5. **Home Health Agency** (7000 to 8499 and 9000 to 9499)

    - "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
    - "Home Health Agency Survey and Deficiencies Report," Form CMS-1572(A)
    - "Statement of Deficiencies and Plan of Correction," Form CMS-2567
    - "Survey Team Composition and Workload Report," Form CMS-670

6. **Portable X-Ray** (X0000001 to X9999999)

    - "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
    - "Request to Establish Eligibility," Form CMS-1880
    - "Portable X-Ray Survey Report," Form CMS-1882
    - "Statement of Deficiencies and Plan of Correction," Form CMS-2567
    - "Survey Team Composition and Workload Report," Form CMS-670

7. **Rehabilitation Agency (OPT/SP)** (6500 to 6989)

    - "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
    - "Request to Establish Eligibility," Form CMS-1856
    - Crucial Data Extract for Form CMS-1893
    - "Statement of Deficiencies and Plan of Correction," Form CMS-2567
    - "Survey Team Composition and Workload Report," Form CMS-670

8. **Rural Health Clinic** (3400 to 3499, 3800 to 3999 and 8500 to 8999)

    - "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
    - "Request to Establish Eligibility," Form CMS-29
    - "Statement of Deficiencies and Plan of Correction," Form CMS-2567
    - Crucial Data Extract for Form CMS-30(E)

- "Survey Team Composition and Workload Report," Form CMS-670

9. ESRD (2300 to 2999 and 3500 to 3799)

- "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
- "Statement of Deficiencies and Plan of Correction," Form CMS-2567
- Crucial Data Extract for Form CMS-3427
- "Survey Team Composition and Workload Report," Form CMS-670

10. SNF and SNF/NF - Titles XVIII and XVIII/XIX (5000 to 6399)

- "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
- "Long Term Care Facility Application for Medicare/Medicaid," Form CMS-671
- "Resident Census and Conditions of Residents," Form CMS-672
- "Statement of Deficiencies and Plan of Correction," Form CMS- 2567
- "Fire Safety Survey Report Crucial Data Extract," Form CMS-2786
- "Survey Team Composition and Workload Report," Form CMS-670

11. NF (A001 to A999, 00-B001 to B999, E001 to E999, and F001 to F999)

- "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
- "Long Term Care Facility Application for Medicare/Medicaid," Form CMS-671
- "Resident Census and Conditions of Residents," Form CMS-672
- "Statement of Deficiencies and Plan of Correction," Form CMS-2567
- "Fire Safety Survey Report Crucial Data Extract," Form CMS-2786
- "Survey Team Composition and Workload Report," Form CMS-670

12. **Intermediate Care Facilities for the Mentally Retarded** (GOO1 to G999, H001 to H999)

- "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
- "Intermediate Care Facility for the Mentally Retarded Survey Report," Form CMS-3070G
- "Statement of Deficiencies and Plan of Correction," Form CMS-2567
- "Fire Safety Survey Report Crucial Data Extract," Form CMS-2786
- "Survey Team Composition and Workload Report," Form CMS-670

13. **Ambulatory Surgical Centers** (C0000001 to C9999999)

- "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
- "Ambulatory Surgical Center Request for Certification in the Medicare Program," Form CMS-377
- "Statement of Deficiencies and Plan of Correction," Form CMS-2567
- "Ambulatory Surgical Center Survey Report," Form CMS-378 and "Ambulatory Surgical Center Report -- Crucial Data Extract," Form CMS-378E
- "Fire Safety Survey Report," Form CMS-2786H
- "Survey Team Composition and Workload Report," Form CMS-670

14. **Comprehensive Outpatient Rehabilitation Facilities** (4500 to 4599, 3200 to 3299, 4500 to 4599 and 4800 to 4899)

- "Medicare/Medicaid Certification and Transmittal," Form CMS-1539
- "Request to Establish Eligibility," Form CMS-359
- "Statement of Deficiencies and Plan of Correction," Form CMS-2567
- "Survey Team Composition and Workload Report," Form CMS-670

15. **Hospice** (1500 to 1799)

- "Medicare/Medicaid Certification and Transmittal," Form CMS-1539

- “Request to Establish Eligibility,” Form CMS-417
- “Statement of Deficiencies and Plan of Correction,” Form CMS-2567
- Crucial Data Extract for Form CMS-643
- “Survey Team Composition and Workload Report,” Form CMS-670

16. Community Mental Health Centers (4600 to 4999 and 1400 to 1499)

- “Medicare/Medicaid Certification and Transmittal,” Form CMS-1539
- “Community Mental Health Center Crucial Data Extract (No CMS number.)

17. Federally Qualified Health Centers (1800 to 1989)

- “Medicare/Medicaid Certification and Transmittal,” Form CMS-1539
- Federally Qualified Health Center Crucial Data Extract

18. CLIA Laboratories (D0000001 to D9999999)

- “Medicare/Medicaid Certification and Transmittal Form CMS-1539
- “Survey Report Form (CLIA),” Form CMS-1557
- “Statement of Deficiencies and Plan of Correction,” Form-2567
- “Survey Team Composition and Workload Report,” Form CMS-670

4149D - OSCAR Input Considerations

(Rev. 1, 05-21-04)

After the kit is reviewed to ensure that the appropriate certification documents are complete and the data is entered into ODIE or ACO, it undergoes a series of edit and consistency checks programmed into the system to screen input errors and data inconsistencies. Depending upon the nature of the error, the data may be rejected or placed in a pending transaction file until corrected information is received and accepted to the record. To assure efficient operation of the system, the SA should be careful that all certification data are completed properly, keyed accurately, and transmitted promptly.

4149E - Suggested Output Utilization

(Rev. 1, 05-21-04)

1 - SA

The SA produces the OSCAR reports identified in subsection B on a regular basis. These reports provide pertinent information concerning the ongoing management of the certification process. The SA uses these as tools in monitoring the status of individual providers and suppliers in the State. Preliminary analysis of facility deficiency profiles (OSCAR Report 17) can help the SA determine the appropriate survey team composition for resurveys. The survey team can use the profiles to familiarize themselves with the histories and characteristics of facilities scheduled for forthcoming surveys based on previous findings and reported corrective actions. For HHA and NH surveys, surveyors should also review the appropriate quality indicator and quality measures reports. OSCAR Report 2 can be utilized to verify internal controls and existing records for scheduling resurveys. Additional management information can be derived from OSCAR Report 5 or 6 since each lists all participating providers and suppliers in alphabetical order by facility name for reference purposes. Also, OSCAR Report 5 or 6 can sort the facilities by provider number order, zip code, or State region code. These reports should help the SA maintain a balanced survey schedule and avoid certification backlogs.

The SA, through careful analysis of OSCAR Reports 18 through 20, can uncover significant State deficiency patterns and reflect a possible need for additional surveyor training or provider consultation in problem areas. The SA can then investigate the causative factors that underlie frequently occurring deficiencies and institute plans for corrective action. Similarly, if a State consistently shows few deficiencies for requirements often out of compliance nationwide, it can explore whether the facilities are strong in that area or if there are problems with the survey process. OSCAR reports may also be used to track selected deficiencies over a specified time period and enable the SA to monitor any changes in deficiency patterns.

2 - RO Usage

Evaluation of SA performance is the most important responsibility of the RO and use of OSCAR data is an integral part of this evaluation. Analysis of data derived from the various OSCAR reports can provide the RO with insights into such areas of SA performance as timeliness of certification actions (OSCAR Reports 9 and 9R) and facility deficiency patterns as compared to other States, regions, and the nation (OSCAR Reports 18-20). OSCAR reports can specifically provide the RO with the tools to:

- Identify overdue recertifications;
- Prepare for SA visits; and

- Monitor SA processing times.

3 - CO Usage

CO calls upon OSCAR to answer informational requests from interested parties (e.g., Congress, public interest groups, governmental agencies) and to supply statistical information to the Administrator of CMS. The data from OSCAR is also used extensively in the general oversight of the certification process on the national level.

4150 - RO Oversight of SA Surveyor Training

(Rev. 1, 05-21-04)

Responsibilities of RO staff for the surveyor training program fall into the following four groupings:

A. To enforce and interpret the SA surveyor qualifications and training statement. The RO:

    1. Determines whether surveyors hired by SAs meet the Federal qualifications requirements;

    2. Assures that new surveyors complete the orientation program and attend the appropriate Basic surveyor Training Course; and

    3. Maintains an updated roster of SA surveyors.

B. To review, approve, and monitor the SA orientation programs for new surveyors. The RO:

    1. Assists States in adapting CMS orientation program to State needs;

    2. Reviews and approves State's proposed orientation program;

    3. Monitors the implementation of the program assuring that each new surveyor completes the orientation program;

    4. Informs new surveyor in training (either when several trainees can come to the RO at one time, or when the regional training administrator visits a State or at some other convenient time and place), regarding the responsibilities of ROs as they relate to their State;

    5. Confers and advises the preceptor and/or coordinator on the administrative and technical issues regarding the orientation program;

    6. Participates in the evaluation of new surveyors' development;

7. Plans, conducts, and coordinates the RO orientation program;

8. Issues a certificate to each surveyor satisfactorily completing the orientation program;

9. Acts as a liaison between CO and the SA in overall implementation, monitoring and evaluation of the orientation program; and

10. Evaluates the in-service training program in the SA as it relates to the continued development of the skill knowledge of the new surveyor.

C. To provide nominations of eligible surveyors for basic and specialty courses. The RO:

1. Maintains accurate information on surveyors who need to attend the basic Surveyor Training Course;

2. Provides CO with nominations for the Basic Course on a timely basis; and

3. Selects attendees to specialty courses and provides the names to CO.

D. To design and carry out surveyor training programs that meet special needs of individual States in the region. The RO:

1. Assists Central Office in assessing training needs of surveyors and participates in task forces developing nationally offered specialty courses; and

2. Based upon analytical studies, identifies training needs of SA surveyors and develops training programs to meet those needs.

4151 -RO Program Analysis Activity

(Rev. 1, 05-21-04)

Program analysis may be focused in the following areas:

4151A - Analysis of Administrative Factors

(Rev. 1, 05-21-04)

Analyze administrative data. This data includes (but is not limited to):

- Level of expenditures;

- Number of surveyors;
- Surveyor turnover rates;
- Number of providers;
- Time and effort statistics; and
- OSCAR reports.

The manipulation of this data may lead to the identification of the causes of performance problems, or help explain differences in survey-related costs.

4151B - Analysis of SA Reviews

(Rev. 1, 05-21-04)

The major focus of analysis of SA evaluations concerns areas where a State shows persistent substandard performance. This may not be evident through periodic reviews, since the reviews do not encompass the same functions. A focus on the results of each area may impact other areas. For example, a high surveyor turnover rate will be evident in financial data (increased training costs) and in 670 data (increased survey completion time). The important element is that several areas of data can be used to demonstrate and support a request for SA corrective action.

SA reviews should also be studied to each other (State-to-State) to determine common areas of success as well as difficulty. These areas should be clearly delineated since difficulties common to most States represent areas where major programmatic efforts should be made to improve program processes.

4151C - Analysis of Individual Special Programs

(Rev. 1, 05-21-04)

The special program or innovation must be directly evaluated. The approach must be one that studies interrelationships among the agency's components. The analysis should determine what work the agency produces, how well and quickly it's produced, and its cost. These considerations must also be studied to determine effects in each area. For example, a program aimed at cost-reduction through a decrease in survey team size may show a trend toward the citing of fewer deficiencies. The results of any analysis should be discussed with the SA with the common goal of improving the quality of survey and certification activities.

4152 – State Performance Measures for All Providers and Suppliers

(Rev. 1, 05-21-04)

(Refer to §7801)

4157 - Federal Monitoring Surveys - Definition and Purpose

(Rev. 1, 05-21-04)

4157A - Definition

(Rev. 1, 05-21-04)

A Federal Monitoring Survey (FMS) is a survey performed by the RO or designated contractors under the authority of the Central or Regional Offices, of any Medicare/Medicaid participating provider and/or supplier (see Chapter 6 for Labs).

4157B - Purpose

(Rev. 1, 05-21-04)

The RO conducts the survey to:

- Monitor SA performance in interpreting and applying Federal standards;
- Identify training and/or technical assistance needs of surveyors;
- Identify problems that surveyors and/or providers encounter in implementing Federal regulations; and
- Require correction of problems that exist in individual facilities or in individual surveys.

4157C - Scope of Survey

(Rev. 1, 05-21-04)

1. Full Survey

A survey of all applicable CoPs and standards for all types of Medicare/Medicaid providers and/or suppliers except SNFs, NFs and ICFs/MR. SNFs, NFs are described separately in 3 below, and ICFs/MR are described separately in 4 below.

2. Partial Survey

A survey of selected Conditions and/or standards for any type of Medicare/Medicaid provider and/or supplier, except SNFs and/or NFs and ICFs/MR. SNFs and/or NFs are described separately in 3 below, and ICFs/MR are described separately in 4 below.

3. SNF and/or NF Surveys

a. **Standard Survey** - A standard survey is composed of Tasks 1-7, and is a resident-centered, outcome-oriented inspection which relies on a case-mix stratified sample of residents to gather information about the facility's compliance with participation requirements. Based on the specific procedures detailed in Appendix P, a standard survey assesses:

- Compliance with residents' rights and quality of life requirements;
- The accuracy of residents' comprehensive assessments and the adequacy of care plans based on these assessments;
- The quality of services furnished, as measured by indicators of medical, nursing, rehabilitative care and drug therapy, dietary and nutrition services, activities and social participation, sanitation and infection control; and
- The effectiveness of the physical environment to empower residents, accommodate resident needs, and maintain resident safety.

If in conducting the information gathering tasks of the standard survey the RO identifies a possible noncompliant situation related to any requirement, it investigates the situation to determine whether the facility is in compliance with the requirements.

b. **Extended Survey** - The extended survey is conducted after substandard quality of care is found during a standard survey. When, based on performing the resident-centered tasks of the standard survey the RO makes a determination that the facility has provided substandard quality of care in 42 CFR 483.13, Resident Behavior and Facility Practices; 42 CFR 483.15, Quality of Life; and/or 42 CFR 483.25, Quality of Care, then an extended survey must be conducted within 14 days after completion of a standard survey. (See Appendix P, Part I, Section III, the extended and partial extended survey.)

c. Partial Extended Survey - A partial extended survey is always conducted after substandard quality of care is found during an abbreviated standard survey. When, based on performing the abbreviated standard survey, the RO makes a determination that the facility has provided substandard quality of care in 42 CFR 483.13, Resident Behavior and Facility Practices; 42 CFR 483.15, Quality of Life;

and/or 42 CFR 483.25, Quality of Care, it must conduct a partial extended survey. (See Appendix P, Part I, Section III, the extended and partial extended survey.)

4. ICF/MR Surveys

a. **Fundamental Survey** - Conducted to determine the quality of services and supports received by individuals, as measured by outcomes for individuals and essential components of a system which must be present for the outcomes of active treatment to occur. Certain requirements are designated as fundamental and are reviewed first. The remaining requirements (that are not designated as fundamental) are supporting structures or processes that the facility must implement. A decision that a provider is in compliance with the fundamental requirements indicates an outcome-reviewed compliance with the non-fundamental requirements and associated Conditions of Participation. (Reference Transmittal No. 278 for specific tag numbers included primarily under 42 CFR 483.420, Client Protections, 42 CFR 483.440, Active Treatment Services, 42 CFR 483.450, Client Behavior and Facility Practices, 42 CFR 483.460, Health Care Services).

b. **Extended Survey** - Conducted when standard-level deficiencies are found during the fundamental survey and the survey team has determined or suspects that one or more CoP examined during the fundamental survey are "not met." The team needs to gather additional information in order to identify the structural and process requirements that are "not met" and to support their condition-level compliance decision. The team reviews all of the requirements within the CoP(s) for which compliance is in doubt.

c. **Full Survey** - A survey of all applicable CoPs and standards. A full survey is conducted by the State Agency at an initial survey and at the discretion of the RO, based on the RO's identification of concerns related to the provider's capacity to furnish adequate services.

4157D - Survey Definitions

(Rev. 1, 05-21-04)

1. Comparative Survey

A Federal survey conducted within 60 days of the State survey to assess SA performance in the interpretation, application, and enforcement of Federal requirements. Whenever possible, the RO conducts comparative surveys within 30 days of the State survey.

2. Direct/Federal Jurisdictional Survey

A Federal survey to assess provider performance and to determine whether a provider/supplier meets all applicable program requirements. It is used as the basis for

approving a provider where the SA lacks jurisdiction. Federal personnel conduct surveys of health facilities of the Indian Health Services, Commonwealth of the Virgin Islands, and participating ESRD facilities in VA hospitals.

3. Validation Survey for Accredited Facilities

A survey of an accredited entity, e.g., hospital, HHA, ASC, to validate the presumed compliance of the entity's deemed status and the survey process of the accrediting organization, recognized by CMS.

4. - Validation Survey of SNFs or NFs

An on-site survey of a representative sample of SNFs or NFs in each State (at least 5 percent of the number of SNFs and NFs surveyed by the State in the year, but in no case less than 5 SNFs and NFs in the State) within 2 months of the date of a State's standard or an extended survey. The sample is of a sufficient size to allow inferences about the adequacy of the State's surveys, and, in conducting a validation survey of SNFs and NFs, CMS uses the same survey protocols the State used.

5. Federal Oversight Support Survey (FOSS)

An on-site SNF/NF survey where the Federal surveyor(s) attends the State survey (initial, recertification, revisit and/or complaint) to observe and assess State surveyor team performance. The RO surveyor(s) may provide training and/or technical assistance to address identified performance needs while on-site as a result of the evaluation of outcomes. The outcomes include:

- Concern Identification
- Sample Selection
- General Investigation
- Kitchen and Food Service Investigation
- Medication Investigation
- Deficiency determination

The Form CMS-2567 is also evaluated to identify whether deficient practices identified on-site are reflected in the Form CMS-2567.

4158 - Federal Oversight Support Survey (FOSS) Expectations and Responsibility

(Rev. 1, 05-21-04)

4158A - SA Responsibility

(Rev. 1, 05-21-04)

Once the survey schedule has been prepared, the SA should forward this schedule to the RO at least two weeks prior to the earliest survey date. This schedule should include:

- Survey dates (including projected end date)
- Facility name and provider number
- SA surveyor names or initials, with the identification of the team leader
- Any use of specialty surveyors
- Type of survey (initial, recertification, complaint, etc)

Once the survey schedule has been forwarded to the RO, and/or the SA has been notified of the selection for Federal oversight, the SA must notify the RO prior to the survey regarding any survey changes (for those selected for FOSS surveys). Changes may be defined as increasing or decreasing team size and composition, altering the survey date, and changing locations. SA justification should accompany the communication of such changes.

During a FOSS, the SA surveyors must inform the RO surveyors when they are or will be conducting certain functions during the survey process. These include, at a minimum:

- Interviews (with staff, family and/or residents)
- Team meetings
- Observations of care delivery

The SA team will share all survey documentation with the RO surveyor(s) for review.

The SA team must determine if Harm, Substandard Quality of Care and/or Immediate Jeopardy are present during the information gathering tasks of the survey and/or during information analysis and decision-making.

Once the FOSS and SA survey have concluded and the SA has documented the compliance decisions, the SA must forward the CMS-2567 to the RO at the same time the CMS-2567 is forwarded to the facility.

4158B - RO Responsibility

(Rev. 1, 05-21-04)

The RO, in preparation for the survey, shall review the survey schedule provided by the SA and notify the State Agency when a survey has been selected for a FOSS. However, an RO may select a survey for an unannounced FOSS.

The RO, in conducting a FOSS will generally perform several steps in gathering information about survey team performance. These include:

- Observing surveyors
- Talking with SA surveyors to clarify observations and interpretations
- Reviewing facility documentation and surveyor notes
- Conducting limited fact finding
- Attending survey team meetings.

The RO surveyor must be able to be present at as many interviews as possible with residents and key facility staff. In addition, the evaluator must be able to be present during all team meetings, investigative activities and during resident care observations as appropriate for their discipline.

The RO surveyor(s) may perform limited fact finding in order to assess the SA survey team's achievement of outcome measures associated with assessing a provider's compliance with Federal regulations. (See FOSS Manual for guidance)

The RO team must provide evaluators to ensure RO to SA ratios of 1:2, but no less than 1:3. The RO surveyors shall not remain on-site if the SA survey team has ended that day's observations and investigations. When the SA leaves the facility, the RO should also depart.

The RO team will debrief the SA survey team regarding the effectiveness of it's survey behaviors in achieving the goals and outcomes of the survey following the completion of the survey, or within the first week the State survey team and RO surveyors return to the office. The RO team will also document the SA team's performance on each outcome that was observable during the survey, and rate that performance by assigning the team a numerical score on each outcome. If appropriate, the RO team will identify SA team training needs.

Upon the conclusion of the FMS (FOSS), the RO team will provide SA management with written feedback on the FOSS at two key points:

- Within 30 days after the completion of the survey, the FOSS Rating and Documentation Form will be provided to the SA.

- Within 30 days after receipt of the facility copy of the Form CMS-2567 by the RO, the FOSS Evaluation Form for Form CMS-2567 will be provided to the SA.

4159 - Selecting and Scheduling Facilities for Monitoring Surveys

(Rev. 1, 05-21-04)

Provider and supplier institutions selected for RO monitoring surveys are usually selected from those the SA recently surveyed. Other criteria for the number and types of institutions chosen include the SA workload, whether the SA is regionalized or centralized, and unique survey problems known to exist in the State. The RO notifies the SA in advance, advising it of those institutions selected for a survey. In cases where the RO wishes the SA to announce the survey beforehand, the SA uses Exhibit 62 to notify the provider or supplier of the date and purpose of the survey.

The SA surveyor may be invited to accompany the Federal surveyors or the Federal surveyors may accompany a SA team, e.g., OSPATS. If LSC enforcement in the State is handled by a subcontracting agency, someone from that agency maybe asked to accompany the Federal LSC inspector.

4160 - Conduct of Monitoring Surveys

(Rev. 1, 05-21-04)

To prevent any misunderstanding about the purpose of the survey, the Federal RO team leader explains the purpose of the survey to provider personnel as the survey begins. The survey usually covers all CoPs. All survey reports are fully completed, but some partial surveys may be conducted to cover selected Conditions or standards.

At a brief exit conference, the RO team gives the provider a general appraisal of it's operation. If deficiencies were found that would significantly affect patient health and safety, the provider is made aware of those particular deficiencies and is cautioned that such deficiencies could result in adverse action by the RO.

Provider Certification Files and Program Reporting

4200 - SA Provider Certification Files

(Rev. 1, 05-21-04)

The certification files the SA maintains can be used as:

- Working files to enable it to carry on correspondence with the providers and suppliers;
- A repository for its copies of the investigative reports and records supporting certification recommendations; and
- A source for statistical and narrative report data that may be requested by the RO.

4205 - Materials Forwarded to RO

(Rev. 1, 05-21-04)

The SA forwards all documents supporting its certifications to the RO as outlined in §2760. To retain a copy of the file, the SA duplicates or obtains multiple copies of the material. When CMS forms are copied, the SA sends the original to the RO. Copies of other material sent to the RO must be legible and must contain the appropriate signature(s), if required.

The files in the RO may be needed to substantiate terminations, reconsiderations, hearings, and appeals. The RO may ask the SA to supply supplementary evidence to support the decisions in these cases. However, whenever an appeal action is pending and the SA obtains additional evidence relating to the certification deficiencies, it immediately forwards copies of this material to the RO without waiting for a request.

4210 - SA Files Used for Case Control and Reporting

(Rev. 1, 05-21-04)

The RO may also need more specific information about an aspect of the certification operations in a State, or may need other special tabulations and reports concerning an area of program activity. Some items of information that may be needed are:

- The status of a facility's Request to Establish Eligibility;
- The number of initial surveys pending;

- The number of applications pending for various lengths of time;
- The reasons that action has not been completed on a certification, e.g., a revisit scheduled;
- Survey schedules; and
- The progress made with a facility.

The SA can use this additional data for its own purposes as well. All such data should be readily available from its records.

4225 - Establishment of SA Case Folders and Controls

(Rev. 1, 05-21-04)

The SA must have an effective case control system. The system of control should be used to maintain a record of every action taken by the SA. The system may be either manual or electronic and must provide easy access to those in the office.

Necessary SA Expenses

4500 - General

(Rev. 1, 05-21-04)

Any class or kind of administrative expenditure that is properly chargeable to Federal funds under plans approved by the Department of Health and Human Services (DHHS) could generally be properly chargeable to State provider certification program funds provided the expenditure is essential to certification functions and in a proper amount. The SA exercises due care in the expenditure of funds, as these funds must be effectively and economically used in carrying out the provisions of the Social Security Act (the Act) for survey and certification activities.

Necessary expenses can include a portion of the cost of operations that serve the certification program and one or more other programs. The SA is required to submit a specific plan for determining the certification program's cost for such multi-program activities as part of the overall plan and budget. Include in the budget both the basis on which the certification program share or ratio is determined and the expenses to which this ratio is applied.

The CMS' current policy is that the total survey costs must be allocated to each benefiting program or activity to determine the payable costs for that program or activity. Knowledge of the State's licensure requirements is necessary in formulating the budget to ensure that cost shares are equitable and in line with current CMS policy. (See §4514.D and E.)

In many States, two or more programs are served by the SA activities, e.g., those relating to certification versus licensure. However, there may be activities that are required by the State survey program only. Under these circumstances, the total cost of these activities would be an appropriate charge to the State survey program.

A State is entitled to receive FFP for Medicaid activities by way of payment or advances to support the reasonable cost of performing services provided for in the agreement with the Secretary or State plan. The "reasonable cost" includes all necessary expenses involved, i.e., expenses that are in accord with these standards and within the limits of the approved SA budget.

4502 - SA Cost of Studies of Distribution of Staff Time

(Rev. 1, 05-21-04)

An important administrative objective is to explore alternative methods of budgeting to facilitate budget preparation, approval, and execution. Studies of the distribution of SA

staff time to various definable areas of State activity within the State survey program may be required. The cost of all studies, recording, and reporting that a State may be requested to do by CMS is considered a necessary expense. The results of such studies are made available to the States.

4504 - Pro Rata Costs - General Rule

(Rev. 1, 05-21-04)

The general rule for prorating costs is that the share apportioned to the State survey program shall not exceed an amount that reflects the ratio of total monies disbursed for personnel services in the State survey program to the total monies disbursed for personnel services in the agency's total program. This total includes the total monies disbursed for personnel services in the State survey program and is based on the calendar quarter for which a report is prepared. This general rule applies except as expressly modified elsewhere.

The basis for apportioning shared costs is a matter of record. All pro rata allocations are to be supported by documentation maintained by the SA. (See §§4508.B and 4510.B.)

4508 - SA Goods, Facilities, Services from Other State Agencies or From Local Agencies

(Rev. 1, 05-21-04)

4508A - Definition

(Rev. 1, 05-21-04)

The definitions of the terms "goods," "facilities," and "services," and the criteria for application of the standards are those in effect for State grant-in-aid relationship with DHHS.

4508B - Centralized State Services

(Rev. 1, 05-21-04)

In some States, services of an administrative nature (including certain commodities) such as accounting, printing, civil service, or central purchasing are furnished to the various operating agencies of the State by specialized service departments outside the health department (or other agency having an agreement and/or State plan with DHHS under §§1864 and/or 1903 of the Act). An equitable part of such charges may be allocated to the State survey and certification program if the services are necessary and are ones from which the program derives a benefit similar to that accruing to other units of the agency, and provided that:

- The pro rata share charged to the State survey program does not include costs attributable to the general expense of State government in carrying out the coordinating, fiscal, and administrative functions of government;

- The charge is based on cost; and

- The costs are extra, identifiable, and readily ascertainable either by segregation or as a pro rata share of the cost of such facilities or services.

The basis of the service agency's charge must be described, including the method of proration and the services provided, and the description submitted for approval to CMS. Such costs should be separately identified in the SA budget.

4510 - SA Personnel Services

(Rev. 1, 05-21-04)

4510A - Selection of Personnel

(Rev. 1, 05-21-04)

Personnel employed for, or assigned to, duties the cost of which may appropriately be charged to DHHS must meet the qualification requirements of, and be appointed and paid in accordance with, the personnel standards contained in the approved State plan, the provisions of the State civil service or other merit system of personnel administration in effect for the designated SA, or the "Standard for a Merit System of Personnel Administration" issued by DHHS.

The costs of all personnel services required to effectively carry out the SA's responsibility under its agreement are proper charges to DHHS. In accordance with prevailing State practice, the SA may include fees for consultants and experts as direct personnel service charges in the personnel services detailed in the budget submittal, or as a contractual arrangement under "other direct charges." (See §4542.)

4510B - Charges for Director and Secretary of State Survey Activities Determined by Pro Rata Method

(Rev. 1, 05-21-04)

In some agencies a director of survey and certification activities is shared with one or more other agency programs. In such cases, the State survey program's share of the director's salary and that of his/her secretary may be determined by a proration method other than time records, provided such method can be shown to be equitable to the State survey program and to the other programs involved. One acceptable method is based on

the ratio of the total monies disbursed for personnel services in the State survey program to the total monies disbursed for personnel services in that segment of the agency having the programs for which this director is responsible (including the State survey program). Quarterly charges for this position would be derived by multiplying the salary paid to the incumbent(s) during the quarter by this pro rata percentage. For purposes of this computation, both the amount representing salary paid to the incumbent(s) and the pro rata percentage would be based on actual expenses in each report quarter.

4514 - SA Determination of Necessary Staff

(Rev. 1, 05-21-04)

4514A - Full-Time

(Rev. 1, 05-21-04)

"Full-time staff" as used here means persons who devote their entire time to the State survey program, and who are employed by the State on a full-time basis.

The number and composition of the full-time staff identified with survey and certification activities should be sufficient to provide for timely and efficient program direction and coordination. The determination of necessary full-time staff is to be based on organizational arrangements and workload in each agency. At a minimum, each agency whose workload requires two or more staff-years of activity in a fiscal year should consider establishing a "full-time" professional position. The incumbent of this position would provide continuous program direction and, as appropriate in the context of agency workload, might also perform line functions.

Neither this section nor Subsection B apply to full-time equivalent positions described in Subsection C.

4514B - Limitation of Full-Time Identifiable Positions

(Rev. 1, 05-21-04)

The number of persons on duty at the end of a monthly reporting period who occupy full-time identifiable positions in the State survey program is limited in any category (professional or clerical) to the number of such positions approved in the budget for that period, unless prior authorization to exceed that number is obtained from CMS.

4514C - Part-Time and Temporary

(Rev. 1, 05-21-04)

To augment the full-time State survey staff with the appropriate professional specialties required to perform State survey activities, the SA is authorized to:

- Recruit part-time or temporary State employees; or
- Arrange for part of the working time of full-time State employees (multi-program staff).

Both types of employees are considered part-time employees to the survey program. As a general rule, consultants are not included in this category unless they are employees of the State. See §4611 for instructions relating to budget requests for consultants' fees.

Provision is made for "equivalent" positions to allow regular agency personnel to perform State survey functions where the agency's regular personnel are already fully occupied and unable to devote time to this function unless the equivalent of the human resources used is added to their regular staff.

Under this concept, an agency that estimated that the aggregate total time of multi-program personnel to be devoted to the State survey program would equal the time of one (or more) full-time person, could hire, with CMS approval, one (or more) full-time person as an "equivalent." In such cases, the agency with approval could also purchase equipment needed by the persons hired. However, it is essential that the individual's time be fully offset by time spent on the State survey program by other staff of the agency. The SA must maintain time records to validate charges to the State survey program.

4514D - Charging for Multi-Program Staff - Program Activities Readily Identifiable

(Rev. 1, 05-21-04)

In agencies where the function performed is separate and readily identifiable as serving the State survey program only, charges for multi-program staff performing State survey functions might be based on daily estimates of time spent on these functions, periodic sample time studies, or continuous time records. Periodic sample time studies must be approved by CMS in advance before the SA can use them as a basis for making charges under this section.

4514E - Charging for Multi-Program Staff - Program Activities Not Separate

(Rev. 1, 05-21-04)

Where some or all of the State survey activities are shared with other on-going agency programs so that a common function, e.g., survey of a hospital, will serve for State survey and certification as well as for licensure or other State programs and the work involved cannot be separated into program elements, time records may not be an appropriate basis for determining cost to the State survey program. The SA may use one of the following methods or submit another proposal for apportioning costs between the State survey program and the other agency program(s) involved.

1 - Cost Due to Acceleration of Usual Agency Functions

Where the agency can identify an increase in its usual workload that is caused by such program requirements as recertification deadlines, the State survey program share would be equivalent to the cost of accomplishing this incremental workload. Charges would be substantiated by records indicating that the usual workload as well as the increase for the State survey program was, in fact, accomplished. If possible, substantiate charges by agency data on human resource requirements necessary for this workload, e.g., previous studies of time or human resources required for surveys of facilities in other agency programs.

2 - Ratio of Specific Workload Requirements of State Survey Program to Total Workload Requirements of All Agency Programs Involved

This method may be used when the SA can identify countable activities (standards) for each type of survey which:

- Need to be evaluated because of the requirements of the State survey program, and

- Others that are related more to the requirements of another program.

The ratio of countable activities required by the State survey program to the sum of the countable activities required by all programs could then be applied to the cost of the multi-program activity. Specific applications of this general principle would have to be developed jointly to allow for circumstances a particular agency may encounter and take into account the comparability of such activities between programs. All such proposals require approval by CMS before charges can be made under them. In some instances the comparability of activities or adjustments made in treating countable activities may have to be verified by later operational studies.

4518 - Use of Overtime in SAs

(Rev. 1, 05-21-04)

The CMS expects the SA to take the initiative in bringing about the adoption of such special measures as it believes necessary to meet workload objectives. To provide the productive capacity to meet certification workloads on a timely basis, all agencies should take steps to secure authority for future use of paid overtime for State survey program staff.

4518.1 - Payment for Overtime

(Rev. 1, 05-21-04)

In the absence of specific State laws or State-wide regulations concerning payment for overtime services, consideration will be given to a State's rules as well as established State practice. Funds advanced to an SA may be used for expenditures for overtime services performed by its personnel under conditions (including rate of pay) authorized by State regulations.

4530 - SA Non-Personnel Services

(Rev. 1, 05-21-04)

Non-personnel services costs, to a substantial degree, will be chargeable directly to the State survey program. Expenses not charged directly may be prorated as indicated in the sections that follow. Generally, each object of expenditure should be either a direct charge in its entirety or a joint charge subject to proration. In justifiable circumstances, however, a portion of expense in an object classification may be charged as a direct cost and the remainder prorated e.g., charges for office space may be based on both direct and indirect costs where one or more rooms are occupied by individuals whose entire time is devoted to State survey activities, and other space is occupied by individuals whose time is devoted only in part to this activity. The basis for apportioning shared costs should be a matter of record and all pro rata allocations should be supported by documentation maintained in the agency.

4531 - Travel by SA Personnel

(Rev. 1, 05-21-04)

The cost of travel, including, where appropriate, per diem or subsistence in lieu of per diem, in the State survey program should be charged in accordance with provisions of State law, regulations, and administrative procedure applicable to travel of State employees.

4531A - Certification and Administrative Travel

(Rev. 1, 05-21-04)

Certification travel includes travel to a facility for initial certification, resurveys for continuing compliance, consultation with a facility applying for certification, and meetings with CMS personnel.

Administrative travel is defined as travel within the State for management purposes related to the State survey program to attend agency administrative staff meetings, State survey program meetings or activities conducted or sponsored by CMS, and planning or liaison visits to other agencies having to do with certification.

Travel expenses for an employee performing activities for the State survey program and other agency programs may be prorated on the basis of individual trips in accordance with distribution of direct personal service time spent on each program involved as recorded for each trip.

Alternatively, such trip records may be accumulated to prorate for an accounting period. For example, if at the end of the period such records showed that a third of the employee's productive time while in travel status was devoted to the State survey program, then the agency would charge a third of the total travel cost to Federal funds (including transportation, per diem, etc.).

In lieu of the proration described above, travel expenses for employees performing activities for the State survey program and one or more other agency programs may be prorated in accordance with the proration of the salary costs of the traveler, or in accordance with the general pro rata formula outlined in §4504, as appropriate.

4531B - Training and Conference Travel

(Rev. 1, 05-21-04)

This category of travel includes travel that is not directly related to line operations of certification, consultation, and administration. Examples are travel performed:

- Incident to orientation and basic training of new employees in areas appropriate to activities in the survey and certification program; and

- To meet the needs of experienced employees for retraining.

Also included is travel related to conferences, meetings, training institutes, workshops, and seminars, if agenda material is directly related to survey functions. Travel for such purposes may be funded by CMS in accordance with the guidelines on training contained

in §4542.2. Travel expenses related to training are to be included in the "Training" line item on the Form CMS-435, line 11.

4532 - SA Communications and Supplies

(Rev. 1, 05-21-04)

4532A - Communications

(Rev. 1, 05-21-04)

Communication expenses include such items as telephone services, telegraph messages (except such items as are payable on travel expense accounts), postage, postage meter charges, printed stamped envelopes, registry and special delivery fees, insurance charges on fourth class mail, or postage-due charges.

4532B - Supplies

(Rev. 1, 05-21-04)

Supply charges include such expenses as:

- General office supplies such as paper, pencils, folders, unstamped envelopes, clips;
- Non-consumable supplies, such as staplers, pencil sharpeners, file baskets, and books, which do not exceed a $25 cost per unit;
- Printing, duplicating expense, and the cost of procuring forms such as printed or duplicated general office forms; and
- Costs of transportation or shipment of any of the above items.

The $25 cost per unit under non-consumables applies unless a different amount is specified by State law, in which case the amount so specified shall control.

4532C - Basis for Charges

(Rev. 1, 05-21-04)

Communications and supplies should be direct charges if separable and identifiable as to unit cost. These expenses may be charged on a pro rata basis (see §4504) or, if equitable, there may be a combination of both direct charges and pro rata charges. For example, if long distance calls are routed through a switchboard or can otherwise be identified as to

program, the State survey program calls can be made a direct charge. Otherwise, all long distance charges should be prorated.

Further, it would not be equitable to charge State survey program for installation and rental of telephones used by the State survey staff and in addition charge a pro rata share of the corresponding telephone costs of other components of the agency.

4534 - SA Office Space

(Rev. 1, 05-21-04)

The cost of office space essential for State survey functions is a proper charge against CMS funds. Such charges may take the form of:

- Rent, service, and maintenance cost in privately-owned buildings;
- Monthly rental charges based on the cost of initial construction or purchase of publicly-owned buildings; and
- Meeting the costs of service and maintenance in lieu of rent in publicly-owned buildings.

In addition, charges may be made for repairs and alterations to either privately or publicly-owned buildings. Payment will be made only for periods of occupancy unless approval is received from CMS for payment for periods of non-occupancy.

4534.1 - Standard of Comparable Rental

(Rev. 1, 05-21-04)

Charges against CMS funds for office space must not exceed the rental rate of comparable privately-owned space in the same or similar locality. Although the rental rate of comparable privately-owned space is not a fixed amount for any particular locality, and the rental rates may vary within a locality as well as between localities, it is expected that a realistic determination of the rental rate of comparable privately-owned space be made. Keep on file the basis and documentation for establishing the rental rate of comparable privately-owned space.

4535 - Rent in Privately-Owned Space

(Rev. 1, 05-21-04)

Charges against CMS funds for privately-owned space, including expenses for services and maintenance, repairs, and alterations, must not exceed the rental rate of equivalent space and facilities in the same or similar locality.

In contracting a lease for privately-owned space, include cancellation or conditional clauses in rental agreements.

The following guides are applicable with respect to the rental of space in privately-owned buildings when renewing an existing lease or when obtaining new or additional space under a lease:

4535A - Cancellation Clause

(Rev. 1, 05-21-04)

When executing or renewing leases, the SA should make every effort to include a reasonable right of cancellation (30 days, if possible) for the State, if such right can be included in the light of rental rates, probable permanency of occupancy, and other pertinent factors. Secure a cancellation clause in all rental agreements covering space for more than one year, if possible.

4535B - Lease Not Exceeding One Year

(Rev. 1, 05-21-04)

When the SA is unsuccessful in securing a cancellation clause, secure leases not to exceed one year's duration, if possible, with an annual renewal option for an extended period such as 3 or 5 years.

4535C - Consulting RO

(Rev. 1, 05-21-04)

Where neither of the above is possible, consult the RO at least 30 days in advance of the date the lease will be signed.

4536 - Space in Publicly-Owned Buildings

(Rev. 1, 05-21-04)

The following standards apply to charges for office space in a publicly-owned building:

A. **Actual Cost -** The amount charged for office space in a publicly-owned building must not exceed actual costs over a long-run period. The agency is required to produce records of actual costs for examination, as necessary.

   The cost of land may not be included as part of the cost of initial construction or purchase of publicly-owned buildings in determining rental charges. This

exclusion is based on the fact that land has no actual physical depreciation. The State would always have the land as an asset long after the building had become obsolete or demolished and value could be realized.

The estimated useful life of the building should be established if depreciation is included as an element of cost. In case the building is vacated before the end of its useful life, past claims for amortization must be adjusted to a reasonable depreciation basis.

B. Cost After Building Amortization - After the initial cost of a building has been amortized, only the costs of service and maintenance may be charged.

C. 75 Percent Rule - The amount charged for office space in a publicly-owned building may not exceed 75 percent of the lowest comparable rental for privately-owned space, unless there are special considerations justifying a greater charge. Use of this standard as an expedient interim measure, in the absence of actual cost data, enables you to claim costs that are not in excess of 75 percent of the lowest cost of privately-owned space without prior review or approval by CMS.

D. Ratio of Charge To Rental Rates In Privately-Owned Space - Experience gained in analyzing the elements of rental rates in privately-owned space shows that approximately 75 percent of the rate represents the expenses of service, maintenance, and depreciation. The portion in excess of 75 percent of the rental rate of comparable privately-owned space generally represents taxes and profit on investment that would ordinarily accrue. Therefore, whenever a charge is made for space in a publicly-owned building that is not in excess of 75 percent of the lowest cost of comparable privately-owned space in the same or similar locality, it may be assumed that such charge is reasonably related to the expense of service, maintenance, and depreciation. The reasonable relationship of such charges to actual costs over a long-run period, however, would be subject to verification.

When a monthly rental charge based on the cost of initial construction or purchase of publicly-owned buildings exceeds 75 percent of lowest comparable rental for privately-owned space, or when the cost of service and maintenance in lieu of rent in publicly-owned buildings exceeds 75 percent, obtain prior approval from CMS.

E. Charge Based on Cost of Initial Construction or Purchase - When rental charges are based on costs of initial construction or purchase of a publicly-owned building, and such charges exceed 75 percent of the lowest comparable rent for privately-owned space, prior to acquisition or occupancy of the space, the SA submits justification for review and approval by CMS.

F. Charges Based on Meeting Cost of Service and Maintenance - When the total charges for service and maintenance in a publicly-owned building exceed 75

percent of the lowest comparable rental for privately-owned space, the SA must submit, prior to its claim, the following data for review and approval by CMS:

- Total useable floor space and the amount of space allocated to the State survey program unit;
- Total costs of service and maintenance and the portion to be charged to CMS funds;
- The elements of cost; and
- The rental cost of comparable privately-owned space, with at least three statements of appraisals.

4537 - SA Repairs and Alterations

(Rev. 1, 05-21-04)

Charges may be made for repairs and alterations in privately-owned or publicly-owned space necessary to maintain proper facilities for efficient administration of the State survey unit.

4537A - Maintenance Repairs

(Rev. 1, 05-21-04)

Maintenance repairs such as painting, repairs to plaster, patching roofs and minor repairs to doors, elevators, electrical equipment, etc., may be included in the rate for service and maintenance.

4537B - Major Repairs and Replacements

(Rev. 1, 05-21-04)

Major repairs and replacements, such as structural changes in buildings, new roofs, new heating systems, etc., may be amortized over a period of years provided the total cost for space on an annual basis does not exceed lowest comparable rental, or in the case of public owned buildings, 75 percent of lowest comparable rental for privately-owned space. If the cost is amortized, the repairs and alterations must be of a permanent nature. Repairs and alterations that remain the property of the agency can usually be classified as moveable equipment.

4537C - Alterations

(Rev. 1, 05-21-04)

Normally, quarters completely adequate to the agency should be obtained from the lessor, and the cost of necessary alterations borne by the landlord. However, where the landlord is unwilling to bear the cost of necessary alterations, CMS funds can be authorized to meet the cost of alterations provided the proposed alterations are needed for better utilization of the space, and the improvements are not obligations of the lessor under the terms of the lease. In some situations, lessors will not agree to make necessary alterations but offer space at a relatively low rental rate. In such cases, the agency may be able to negotiate an arrangement under which the lessor would make necessary alterations and the agency would amortize the cost by an increase in rent for a stipulated length of time. Before agreeing to an arrangement providing for repair or alteration, an agency should first secure approval from the RO.

4538 - SA Identifiable (Direct) Costs

(Rev. 1, 05-21-04)

An SA that is locating program personnel in extra identifiable space should charge CMS funds for the cost of such space. Where State survey program personnel share space with the agency's regular personnel, the cost of such space shall be apportioned between the programs. Apportionment is based upon a proration plan submitted by the SA and approved by CMS. The approved method applies only to rental fees paid for locations where State survey program personnel share occupancy. Bases for prorating rental costs should be reappraised when changes in physical facilities or other conditions results in inequitable cost sharing. The SA is required to submit a rental cost apportionment plan each year as part of the budget documentation. Approval of the budget constitutes approval of the plan of apportionment.

4539 - SA Office Maintenance

(Rev. 1, 05-21-04)

A - Definition

Office maintenance includes services such as light, heat, time clock and water service, towel and janitor service, and machine repair service prorated on the same basis as rent, provided such services are not already included in rental costs.

B - Basis for Charges

If associated office maintenance cost, in whole or in part, is included in a rental contract, it need not be separated but note the inclusion. Maintenance costs that are not included in rentals may be charged on the same basis as rental costs.

4540 - SA Equipment

(Rev. 1, 05-21-04)

4540A - Definition and Quality of Office Equipment

(Rev. 1, 05-21-04)

Items that are of a non-expendable nature, that is, have a life expectancy of one year or more and a probable resale, salvage, or trade-in value, are classified as office equipment if they have a unit cost in excess of $25. However, if State law specifies a different amount, the amount so specified shall apply. The quality of items should not exceed the quality of similar office equipment in general use in other offices of the agency.

4540B - Title to and Accountability

(Rev. 1, 05-21-04)

Title to and accountability for office equipment purchased for State survey program purposes, or for shared use with other State or Federal programs, shall rest with the State. However, the purchase price(s) of individual pieces of office equipment may be shared with other State and/or Federal programs. Where the costs of equipment are prorated between Medicare and other programs, the same proration must be used in crediting residual value to the Medicare program of all disposed equipment. Where Medicare funds are used to fully fund equipment, 100 percent of the residual value must be credited to Medicare.

4540C - Purchase of Equipment

(Rev. 1, 05-21-04)

1 - State Practice

For equipment purchased for the State survey program, follow established State law or regulations for procurement of equipment.

2 - Purchases Related to Budget Process

Funds for equipment purchases will be requested by SAs and approved by CMS as part of the budget process. The SA should anticipate the bulk of its equipment needs for the budget period during pre-budget planning, and request needed equipment in the budget submittal. To estimate equipment needs, the SA should examine the condition of equipment on hand, and consider any proposed staff increases.

The total expended for equipment during a budget period cannot exceed total funds allocated for equipment for that period without prior approval of the RO. Budget requests should, therefore, include items which were approved in the prior budget period but which will not be paid for in that period.

3 - Items Deleted by CMS

After reviewing an SA's estimate for equipment, CMS may delete an item or restrict the purchase of such an item. When CMS deletes an item, the SA may submit another request with added supporting information. However, unless the restriction is removed, the item cannot be purchased with Federal funds.

4 - Purchase of Items Not Included in Budget Submittal

Although the SA is expected to anticipate the bulk of equipment needs, occasionally a need for equipment that was not included in the budget submittal may arise. The SA must receive approval of the RO, before purchasing such items of equipment. However, if sufficient uncommitted funds are available, the SA may purchase items not included in the budget approval without prior RO approval when the unit cost of the item is $50 or less, and the item is of a kind approved in any previous budget period, e.g., tables, chairs, coat racks. Such items should be listed and identified in the equipment schedule submitted at the end of the quarter in which purchased.

5 - Reporting Equipment

The SA is required to maintain an inventory of equipment following usual State inventory practices, and make an annual physical count of equipment items for comparison against the inventory records. In the event of equipment loss and/or substantial damages due to theft, fire or weather, the SA submits a statement concerning such losses to the RO as soon as possible.

4540D - Rental of Equipment

(Rev. 1, 05-21-04)

Situations may occur where it will be advisable to rent certain office equipment instead of purchasing it. Providing rental of office equipment is not contrary to State law or regulations, expenditures for such rental are considered "necessary" if:

- The rental is for a short period of time;
- The equipment is not available for purchase (e.g., leased telephone lines, electrostatic photocopy machines); or
- Proof that renting rather than purchasing an item of equipment is advantageous in terms of cost.

The SA secures prior approval of the RO if it wishes to rent equipment for more than 90 days.

4541 - SA Retirement and Social Security

(Rev. 1, 05-21-04)

A - Retirement Contributions

Retirement contributions include the SA's cost (not employees' share) of contributions to retirement funds such as State retirement, social security, etc.

B - Prorating Costs

Where the SA prorates the personal services costs of State survey personnel, the retirement costs for these personnel are to be prorated.

4542 - Other SA Expenses

(Rev. 1, 05-21-04)

Other expenses include expenditures which can be properly charged to the State survey program, but which have not been provided for in any of the preceding classifications. Examples of such items are discussed below by category.

4542.1 - Consultants Expenses

(Rev. 1, 05-21-04)

Consultant services are generally defined as being furnished by persons who are not State employees, but who will be used on a part-time, temporary, or fee-for-service basis to provide needed skills to the State survey program. State practice will be the determining criterion in distinguishing between consultants and part-time personnel for purposes of allocating charges to the State survey program.

4542.2 - SA Expenses for Training of SA Personnel

(Rev. 1, 05-21-04)

The cost of training personnel engaged in title XVIII and title XIX survey activities is chargeable to the State survey program when the training is related to the State's responsibilities for survey and certification activities.

Training includes attendance at job-related meetings, conferences, seminars, workshops, or training courses. Training which is considered related to the SA's responsibilities includes attendance at meetings, courses, etc., where the subject matter concerns one or more areas in the certification requirements related to appraising the activities of a health facility. This may include areas such as medical records, dietary services, infection control, etc. Other training considered related to the SA's responsibilities includes attendance at professional meetings that enable individuals in the various health disciplines who are engaged in titles XVIII and XIX to stay abreast of pertinent developments affecting the inspection and approval of health facilities. Examples of professional meetings at which attendance could possibly be funded, subject to the considerations outlined here and in succeeding paragraphs, are the annual meetings of the American Hospital Association, American Public Health Association, American Dietetic Association, and similar national or regional organizations.

4542.2A - Funding

(Rev. 1, 05-21-04)

The CMS will fund the entire cost of such approved training of full-time employees and generally will pay a proportionate share for the training of part-time employees, e.g., 50 percent for employees who work one-half time on State survey activity. The State should include the cost of travel relating to training in the dollar figure requested for training. However, with specific justification, where the training meeting or course is primarily concerned with subject matter that directly relates to the SA's responsibilities in carrying out survey and certification activities, CMS will fund the entire cost of training of part-time employees. All funding for training is subject to the following considerations:

- Out-of-State attendance must be in accord with established State rules and regulations (**NOTE**: When Federal requirements mandate that the training is necessary, a State's travel policy for out-of-State travel is not an excuse for non-participation in the Federal training);

- Federal funds may not be used for attendance at any meetings, if the attendee is paid by the sponsoring organization for attending, for speaking, or for rendering other services in connection with the meeting; and

- Attendance will not significantly impair progress of certification activities.

4542.2B - Requesting Approval

(Rev. 1, 05-21-04)

Request funds for conferences and short-term training activity in the annual budget submittal. Activity of this nature that has not been provided for in the approved budget must be approved by the RO on a case-by-case basis.

At a State's request, CMS will include a dollar authorization for short-term training activity over and above the cost of attendance at CMS-sponsored meetings within the funds approved for each fiscal year. This authorization covers travel, per diem, admission fees, and any other costs related to attendance at the meetings.

Justification for the request, other than the relationship to professional staff-years, is not required provided that the total amount requested does not exceed the approved budget. (If the agency believes it necessary to exceed the allotment, see Subsection C below.) Up to the limit of funds approved in response to such a request, the SA can make expenditures for short-term training activities without consulting the RO for specific authorization provided that all of the following conditions are met:

- No single meeting will be attended more than five working days;

- The proposed attendees are professional State employees who regularly perform State survey functions;

- The training is related to SA responsibilities as defined at the beginning of §4542.2; and

- A State can not charge a higher percentage of the cost of attendance by part-time employees than the percentage of time they devote to the State survey program, as indicated by the percentage of the employee's salary reported on the State Survey Agency Budget/Expenditure Report (Form CMS-435) for the most recent complete calendar quarter.

If the employee came on duty during that quarter or later, the SA charges the percentage applicable to the employee in the budget approval. The SA ensures that there is adequate documentation of every expenditure following State practice, for subsequent audit.

Where one or more of the preceding conditions are not met with respect to any particular meeting, the SA furnishes detailed justification as explained in Subsection C below.

Authorization of funds for short-term training is in addition to the cost of attending any meetings called by CMS. The SA should consult the RO for budget information about proposed CMS meetings as part of the process of preparing the budget submittal.

4542.2C - Justification for Attendance

(Rev. 1, 05-21-04)

Where it is necessary to furnish detailed justification to the RO for attendance at short-term meetings, either in the original budget or later in the fiscal year, e.g., the criteria in Subsection B,

Above, will not be met, or the allotment has been exhausted, the SA provides the following information:

- Name and position title of each person proposed for attendance;

- A list of previous out-of-State training meetings attended by each proposed attendee during the current fiscal year (other than CMS-sponsored meetings) which were charged to Federal funds;

- Whether each proposed attendee is full-time or part-time. If part-time, the SA provides the percentage of time charged to State survey activities on the most recent Quarterly Expenditure Report (or for a new employee, the percentage approved in the budget) and the percentage of costs the SA proposes to charge to the State survey program. If the latter percentage is higher, the SA includes justification explaining how the meeting or course directly relates to the employee's State survey activities or, where appropriate, showing how the percentage of the employee's time reflected in the most recent Quarterly Expenditure Report is not indicative of the time the employee regularly devotes to the program;

- An itemized listing of proposed expenditures for attendance, including travel, per diem, and admission fees; and

- Name, location, and dates of the meeting, the subject matter on the agenda and the name and address of the sponsoring organization. Where the description of the subject matter does not clearly establish that the subject matter relates to SA

responsibilities, it includes an explanation of how the subject matter relates to the survey and certification process.

4542.2D - Fiscal and Reporting Considerations

(Rev. 1, 05-21-04)

This pertains to the amount requested for travel costs of such activity. The total amount approved and expended is shown on line 11 of Form CMS-435. The amounts reported as expended need not be broken down by specific meetings or conferences. However, the SA keeps detailed records of all expenditures for regular audit purposes.

4542.2E - Educational and Training Leave

(Rev. 1, 05-21-04)

Educational leave is leave granted for specialized professional or technical study in an accredited educational institution. Training leave is leave granted to an employee for attendance at short-term courses that will run longer than five working days, outside the agency. Approval of educational or training leave can only be granted if it is for purposes related to carrying out SA survey responsibilities. Additionally, State rules and regulations and practice must permit taking of leave for such purposes.

Approval of training or educational leave is claimed in advance from the RO. Such proposals are considered individually, based on the specific circumstances involved. Requests are to include the following:

- Employee's name, type of appointment held, position and grade, length of service with the SA, previous experience and education;
- Description of any other specialized training or courses taken by the employee within the previous 24 months;
- Name and location of training institution;
- Title and description of training in sufficient detail to demonstrate its scope, content, and how it relates to the SA's survey and certification responsibilities;
- A statement indicating how this training will benefit the employee's work and improve the agency's activity;
- The training period, showing the number of days and hours the employee will be absent from duty;

- A statement from the supervisor dealing with the ability of the unit to forego the services of the trainee during his/her absence; and

- The cost of tuition, fees, books, in detail.

4542.2F - Agreements by Employees to Continue on Job

(Rev. 1, 05-21-04)

In order to discourage resignation of an employee for whom there has been a considerable expenditure for formal training, some States require the employee to sign an agreement that he/she will remain on the job for a certain length of time (e.g., 6 months) after completion of the training. If State regulation or practice provides for such agreements, after obtaining RO approval for the activity, the SA has the selected employee sign such an agreement.

4542.3 - Miscellaneous SA Expenses

(Rev. 1, 05-21-04)

Items illustrative of this category are bonding and public liability, equipment rental, SA cost (not employee's share) of workmen's compensation, group insurance, unemployment insurance, proportionate share of merit system of civil service charges, etc.

4542.3A - Bonding

(Rev. 1, 05-21-04)

Where a new bond or an amendment to an existing bond is required in relation to receiving and handling Federal funds, the cost of such bond, when borne by the State, or the additional cost attributable to an amended bond is a proper charge.

4542.3B - Public Liability

(Rev. 1, 05-21-04)

An appropriate share of the cost to a SA for protection against financial responsibility for injury to person(s) or property is properly charged to CMS when such expenses are in the form of premiums for public liability or property damage insurance. The cost of awards, judgments, or settlements arising from injury to person(s) or property are not chargeable to CMS.

The share of public liability and property damage insurance costs properly chargeable to CMS, in the case of motor pool or personally-owned vehicles used in the discharge of a

State's official business will be proportionate to that share of all agency personnel which is devoted to activities directly concerned with the State survey program.

The other items mentioned above may be prorated or charged directly, as appropriate. If prorated, the method of prorating should be appropriate and acceptable to the State and to CMS. Thus, the costs of workmen's compensation, group insurance, or unemployment insurance would usually be charged directly for employees whose salary costs are prorated in the same ratio as salary costs.

4543 - NAR/NATCEP

(Rev. 1, 05-21-04)

The allowable costs that can be charged to the Medicare State certification program for activities involving NATCEP testing are outlined in §1819(e)(1) and (2) of the Act. These costs relate to the State requirement to specify and review NATCEPs together with establishing and maintaining a NAR. The State is required to conduct these activities as part of its §1864 agreement as authorized by §1864(d) of the Act. The actual training and competency evaluation testing of nurse aides is not paid under the §1864 agreement, and therefore is not payable as part of this agreement.

All expenses incurred for title XVIII-only NATCEPs and the NAR are to be reported on Form CMS-435 as a separate line item under Miscellaneous. The Medicare survey and certification budget allows sufficient funds for this purpose.

Expenses incurred for title XIX-only facilities for NAR/NATCEP are considered administrative costs and are to be reported on the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program," Form CMS-64. There are no provisions in the survey and certification budgets for these expenses.

Costs incurred in joint title XVIII/XIX facilities for NAR/NATCEP are to be split 50-50. Report expenses incurred for title XVIII on Form CMS-435 and expenses for title XIX on Form CMS-64.

4544 - LTC Facility Workload (SNF/NF)

(Rev. 1, 05-21-04)

The certification requirements for SNFs and NFs in the Medicare and Medicaid programs are virtually identical. The same staff must perform the survey activity relating to SNF/NFs. This ensures that interpretation of the regulations to the provider remains consistent regardless of program participation. In addition to surveying SNFs, the same staff may survey ICFs/MR for the Medicaid program in order to consolidate survey activities being performed for both programs.

The Federal share of the costs of the survey and certification activities and follow-up visits related to surveys of nursing homes participating in both titles XVIII and XIX are to be divided equally by the two programs. FFP in the costs for each program are to be in accordance with regulations pertaining to the respective program. Costs of survey and certification activities and follow-up visits related to surveys of ICFs/MR are to be chargeable entirely to title XIX in accordance with Federal regulations.

The costs of activities performed by this survey staff for purposes of the State licensure program or any other State program must be borne entirely by the State. The SA maintains records to reflect the costs of these activities. Time records having prior approval by the RO are used to support the actual charges made to either the Medicaid or Medicare program.

Since a portion of the survey and certification costs for Medicaid continues to be borne by the State, it is necessary that the budget and activity plan be submitted to the SMA for review and approval. This procedure will also assure proper coordination and scheduling of survey and certification activities by the SA with the medical review and UR responsibilities of the title XIX agency.

The Budgetary Process

4600 - SA Budget Request

(Rev. 1, 05-21-04)

The annual funding allocation cycle begins in June/July of the preceding FY when CO issues a budget call letter to the ROs and SAs, providing guidelines and program priorities to assist in the SAs annual budget request preparation and ROs with State budget negotiations.

Beginning in FY 2003, State Agencies should submit initial budget request documents and forms in accordance with instructions contained in the current State Survey and Certification Budget Call Letter. Furthermore, once a Fiscal Year budget allocation has been provided, the SA will be requested to prepare a Form CMS-435 and supporting budget forms via the State Survey and Certification and CLIA automated reporting system. The Automated Reporting System is a web-based application provided by CMS. The automated reporting system replaces the system of manually preparing and submitting reports. Supporting documentation is to be provided via e-mail, or common carrier.

In the event a congressional appropriation is not passed at the beginning of the Federal FY (October 1), Congress approves a continuing resolution that allows work to continue at the prior year funding level.

A - Expenditure Categories to Be Shown

The SA budget request should be a detailed estimate of State survey program costs for both LTC and non-LTC requirements. Such costs are to be classified according to the category of proposed expenditure. The estimate of each category must be completely explained with respect to program objectives, the State Agency's plan of operations, and the method used to compute the request. Funds provided to agencies as a result of the budget request are to be used only for necessary expenses. (See §4500.) States are free to shift funds from one expenditure category to another, except State surveyor training funds, which may only be re-designated with RO prior approval.

B - Due Date

Each SA is to prepare the budget in accordance with the due date provided by CO to ensure that CMS can complete the budget approval process in time to prevent an interruption to cash flow when one FY ends and the succeeding year begins.

C - Budget Summary

The SAs are to complete Form CMS-435 (see Exhibit 45) State Survey Agency Budget/Expenditure Report and Form CMS-434 (see Exhibit 52) State Survey Agency Workload Report for both non-LTC and LTC requirements. Form CMS-435 is a multi-purpose form (budget request and approvals, expenditures reports, supplemental funding request, etc.) used in Medicare and Medicaid applications. Its various uses are displayed at the top of the form. The SA indicates the specific use of the form by checking the appropriate box. These forms summarize requested funding levels for each category of expense and provide projected workload. The SA budget request must also include documentation as outlined in the annual budget call letter and a Form CMS-1465A (Exhibit 47) - "State Agency Budget List of Positions"; Form CMS-1466 (Exhibit 54) - "State Agency Schedule for Equipment Purchase," and any other form in accordance with instructions contained in the current State Survey and Certification Budget Call Letter.

D - Line Item Budget Justification

Explanations for specific categories of expense are essential in both budget preparation and subsequent analysis. Therefore, the budget request must contain complete rationale regarding each line item. Line item justification should consist of narrative statements providing specific rationale for budgetary needs.

4605 - Developing SA Budget Justification

(Rev. 1, 05-21-04)

The following instructions are provided to assist the SA in the development and preparation of its budget request. (§§4605-4628.)

A - Base Data

The basis for estimating line item expenditures is the State's projected workload together with historical costs. Consideration should be given to additional workload projected in the next Federal FY, such as newly established provider groups and initial inspections for facilities requesting program participation. Prior year expenditures may serve as a guide in computing expected increases or decreases in each line item for the budget year.

B - Line Item Justification - General

Projected workload together with the impact of expected program developments and emphases, the State's own plan and historical costs are to be translated into specific line item justification. The SA should develop the budget estimate using these factors as a guide.

C - RO Assistance

RO personnel are available to assist the SAs in preparing budget requests. The SA should consult with the RO on any problem or questions as early as possible in the budget preparation process.

4610 - Line Item Justification for SA Personnel Services

(Rev. 1, 05-21-04)

A - Full-Time Positions

The budget justification describes the organizational location of the staff and how it functions in relation to the workload included in the work plan. The SA lists the positions on Form CMS-1465A (see Exhibit 47) in accordance with §4612. The SA completes a separate Form CMS-1465A listing the positions requested for title XVIII non-LTC, title XVIII LTC, and title XIX LTC. The SA prepares three Forms CMS-1465A with its annual budget request.

B - Approval To Exceed Authorized Full-Time Staffing

The RO will place limitations on the number of full-time equivalents (FTEs) charged to Medicare program budgets so the SA cannot exceed the approved full-time staff without prior RO authorization. This ensures that ROs can track onboard surveyor disciplines and analyze fund requirements for support of additional staff. RO recommendations for staffing under the Medicaid program represent Federal estimates of required survey personnel.

C - Part-Time and Temporary

The SA is authorized to augment the full-time staff with the appropriate professional specialties and other positions required to perform the State survey activities and to secure the services of such persons on a part-time or temporary basis. Specific rationale for the need for such positions and skills are required in the line item justification, relating these manpower needs to activities and staff-days noted in the work plan. The SA details the basis for determining charges for part-time or temporary services in the line item justification and lists the positions requested on Form CMS-1465A in accordance with instructions stated in §4612.

4611 - Line Item Justifications for SA Direct and Indirect Costs

(Rev. 1, 05-21-04)

In making the entries for items under non-personal services (Other Direct Costs, lines 5 through 14, of Form CMS-435), the SA is required to justify the amounts approved by

providing the rationale developed for each line item separately, using base period data and format as described in §4605. Specific guides and criteria are listed below.

A. Retirement Contributions and Fringe Benefits

The SA enters the estimated total of the employer's share of social security taxes, State retirement system(s) contributions and other fringe benefits. Also, the SA indicates the percentage used to determine the level of funding for Retirement and Fringe Benefits.

B. Travel

The SA includes the estimated travel costs of its personnel, including, where appropriate, per diem or subsistence in lieu of per diem, applicable to the State survey program. The SA derives estimated costs based on provisions of State law, regulation and administrative procedures applicable to travel of State employees. The SA indicates in the budget estimate expected number, type and extent of trips, and purpose. For out-of-state travel, the SA indicates the number of trips, the purpose, and basis for charges to the State survey program. The SA includes the basis for charges for all out-of-State travel other than to meetings called by CMS.

C. Communications

In the budget estimate, the SA breaks out e-mail, telephone, telegraph, postage, and other communications separately.

D. Supplies

In the budget estimate, the SA breaks out all major items of supplies, i.e., any supplies comprising 20 percent or more of the total cost of supplies.

E. Office Space

1 - Agency In Identifiable Space

Analysis of base period expenditures and the budget estimate must contain these elements for each location: total rental costs, number of square feet of space, cost per square foot, and services included in rental. The SA identifies office space that is State-owned.

2 - Office Space - Agency In Shared Space

SA analysis of base period expenditures and the budget estimate must contain these elements:

- Total cost of space to the agency;

- Basis of proration;
- Office locations of SA staff; and
- Estimate of square feet allocated to the State survey program. The SA identifies State-owned space.

3 - Office Maintenance

In the budget estimate, the SA breaks out the major items of expense, e.g., light, heat, janitorial service, office equipment repair. If office maintenance, in whole or in part, is included in the SA rental contract, the SA notes this fact and the amount need not be separated.

F. Equipment

The SA enters costs of equipment to support specific personnel positions such as desks, chairs, typewriters, computers and computer-related equipment, file cabinets, tables, and other machines (fax machines, photocopiers, etc.) that are necessary for program operational, administrative and management needs. In addition to line item justification, the SA documents the budget estimate through use of Form CMS-1466 (Exhibit 54) for both LTC and non-LTC requirements. (See §4614.)

G. Training

The budget estimate should provide for the cost of training SA personnel. The SA includes the cost of travel and per diem associated with training sessions.

H. Consultants

The SA provides the estimated cost of consultants who are not State employees, but who are used on a part-time, temporary, or fee-for-service basis.

I. Subcontracts

The SA provides the estimated cost of subcontracts when part of its responsibilities are assigned to another State or local public agency. Subcontract costs attributable to State survey activities (e.g., State Fire Marshal) are allowable and payable at the FFP rate established for surveyors, i.e., 100 percent Federal payment for Medicare and 75 percent/25 percent FFP for Medicaid, with the exception of ICF/MRs. The Federal matching rate for ICF/MRs is 75 percent of FFP for salary, fringe benefits, travel and training. All other costs are matched at 50 percent FFP.

J. Miscellaneous

The SA provides the estimated cost of other items, which have not been reported in any of the preceding classifications. Also, the SA enters as a separate line item anticipated cost associated with the NAR and NATCEP, line 14A. (See §4543.)

K.. Total Direct Costs

Calculated sum total cost of all line items outlined here and in §4612.

L. Indirect Costs

The SA provides the rate negotiated and approved by the Director, Division of Cost Allocation and Liaison, DHHS, for use during the budget FY together with the line item base, against which it is applied.

Expenditures included in this category must not be duplicated under direct costs.

M. Total Budget Request

Calculated total of all direct and indirect costs.

4612 - Preparation of State Agency Budget List of Positions, Form CMS-1465a (Exhibit 47)

(Rev. 1, 05-21-04)

A - Usage

This form is applicable for both LTC and non-LTC budgeted positions. The SA prepares a separate Form CMS-1465A of staff years and salaries for title XVIII non-LTC, title XVIII LTC, and title XIX positions. The SA prepares three Forms CMS-1465A with its annual budget request.

B - Heading

The SA verifies the pre-filled official name of the agency and inserts the period for which funds are requested.

NOTE: The SA includes overtime needs for all categories of positions listed, and provides detail justification explanations for the estimated costs.

The SA must not enter positions on Form CMS-1465A, which represents consultants (i.e., personnel who perform services on a fee basis and are not employees of the State). The SA shows funds for such services in Other Direct Costs, line 12 of Form CMS-435.

The SA must not enter positions on Form CMS-1465A, which represents personnel related to NAR or NATCEP. The SA shows funds for such services in Other Direct Costs, as a separate line item in Miscellaneous of Form CMS-435. (See §4543 for instructions pertaining to costs incurred for NAR/NATCEP.)

C - Positions - Column Entries

1. Column (A), Position Title/Name

The SA lists each position and person's name. A full-time incumbent position:

- Will work full-time on the State survey program on a continuing basis;
- Whose time will be subject to cost allocation between State and Federal programs.

Where applicable, the SA indicates after the position title whether part-time (PT) or temporary (T) and subdivides positions into three classifications (surveyor, nonsurveyor professional and clerical) to simplify preparation of totals and for CMS review.

2. Column (B), City Where Located

The SA shows the city where the incumbent is located. If all positions are located in the same city, the SA shows the city on the first line followed by: (all).

3. Column (C), Number of Positions

The SA enters the total number of positions planned for the FY shown on the corresponding line of column (A).

4. Column (D), Staff-Years

The SA enters the total staff-years to be worked during the FY by the incumbent(s) for the position shown on corresponding line of column (C). For full-time positions whose incumbents are on duty at the beginning of the fiscal year, this is the same number as shown in column (C). The time shown in staff years for full-time positions should be the time that it is anticipated will be spent in that program for which the budget request applies. The SA determines staff-years for new full-time positions based on the quarter the incumbent is expected to enter on duty, as follows:

Entrance Quarters	Staff Years
October-December	1.00
January-March	.75
April-June	.50
July-September	.25

The staff-years shown for part-time or temporary positions are derived by multiplying the percentage of time to be applied by the number shown in column (C).

5. Column (E), Funds Required

The automated system calculates the total funds required by multiplying column (D) Staff Years and column (F) Annual Salary.

6. Column (F), Annual Salary

The SA enters the annual salary for each full-time position presented in column (A) including part-time and/or temporary positions.

D - Totals

After completion of column entries, the automated system tallies the salaries of all positions. These salaries should then be entered into the appropriate section on Form CMS-435, Salaries; line l and 2.

E - Certification: Date, Signature, and Title

The automated system dates the Form CMS-1465A. The SA certifying official enters their name and title.

4614 - Preparation of State Agency Schedule for Equipment Purchase, Form CMS-1466 (Exhibit 54)

(Rev. 1, 05-21-04)

A. Usage

This form is applicable for both LTC and non-LTC equipment requests and purchases. The SA prepares a separate equipment purchase schedule for title XVIII non-LTC, title XVIII LTC and title XIX LTC equipment and prepares three separate Form CMS-1466s with its annual budget request.

B. Heading

The SA inserts official name of the agency, indicates which program and facility type (type XVIII LTC, XVIII non-LTC, or XIX LTC) and enters the name of the State in the designated space and the period for which equipment funds are requested. When equipment is actually purchased, the SA prepares a revised Form CMS-1466 with the next quarterly expenditure report.

C. Column Entries

1. Column (A), Description of Equipment - The SA enters the items of equipment requested or reported as purchased. Note with an asterisk or other notation items previously approved by the RO, but which are being re-budgeted. On separate form, the SA explains why the purchase was not completed in the prior budget period.

2. Column (B), Number of Items on Hand - The SA lists the number of items on hand in the State survey unit as of the time the form is being prepared which are similar to the item requested. If a new and different item, enter zero ("0") or leave blank in this column.

3. Columns (C) and (D), Number of Units (Additional) or (Replacement) - The SA lists the number of units in the appropriate column, (C) or (D).

4. Column (E), Unit Cost - The SA enters the unit cost for each item listed in column (A).

5. Column (F), Gross Cost - The automated system computes and enters the gross cost for each item in column (A) by multiplying the number of units in columns (C) or (D) by the unit cost, column (E).

6. Column (G), Trade-In Value If Replacement Item - The SA enters the trade-in value for any replacement item presented in column (A).

7. Column (H), Net Cost - Calculated value by subtracting column (G) from column (F).

D. Total Net Cost of Equipment

The automated system sums all amounts shown in column (H). The SA should enter this value on Form CMS-435, line 10, in the appropriate column.

E. Certification: Date, Signature, and Title

The automated system dates the Form CMS-1466. The SA certifying official enters their name and title.

4625 - Preparation of State Survey Agency Budget Request - Non-Long-Term Care, Form CMS-435 (Exhibit 45)

(Rev. 1, 05-21-04)

A. Usage - Form CMS-435 is a multi-purpose, multi-program form. The SA can include its budget requests for title XVIII LTC and non-LTC, as well as title XIX LTC, on one Form CMS-435.

B. Heading - Automated system inserts the official name of the State agency, enters the appropriate Region and State Code. The SA enters the FY for which funds are requested.

C. Rounding To Next Higher Dollar - In preparing Form CMS-435, the automated system rounds dollar amounts of funds requested for each line item to the next higher dollar.

D. Salaries - Secure totals for professional and clerical staff-years, and money amounts from the accompanying Form CMS-1465A. Place totals in appropriate columns. Separate reporting is required for title XVIII NLTC and title XIX positions. The funds requested to support activities carried out under title XVIII, title XIX and the State are to be based on the proration of staff time determined to be supportable by Medicare, Medicaid, and the State as negotiated with the CMS-RO. (See §4514.)

E. Other Direct Costs - Enters estimates for these categories as developed in the narrative justification. (See §4611.)

F. Total Direct Costs - Automated system adds lines 3 and 15 of the appropriate column.

G. Indirect Costs - Enters the rate and the base against which the rate is charged. (See §4611.) Expenditures included in this category must not be duplicated under direct costs.

H. Total Budget Request - Automated system totals lines 16 and 17 and enters the Total Costs in Line 19.

I. Certification: Date, Signature, and Title - The automated system enters the date for budget request. In the signature space, the SA's certifying official types their name and title.

4626 - Preparation of State Survey Agency Budget Request - Long-Term Care, Form CMS-435 (Exhibit 45)

(Rev. 1, 05-21-04)

A. Usage - Form CMS-435 is a multi-purpose, multi-program form. The SA can include its budget requests for title XVIII LTC and non-LTC, as well as title XIX LTC, on one Form CMS-435.

B. Heading - Automated system inserts the official name of the State agency, enters the appropriate Region and State Code. The SA enters the FY for which funds are requested.

C. Rounding To Next Higher Dollar - In preparing Form CMS-435, the automated system rounds dollar amounts of funds requested for each line item to the next higher dollar.

D. Salaries - Secure totals for professional and clerical staff-years, and money amounts from the accompanying Form CMS-1465A. Place totals in appropriate columns. Separate reporting is required for title XVIII LTC and title XIX positions. The funds requested to support activities carried out under title XVIII, title XIX and the State are to be based on the proration of staff time determined to be supportable by Medicare, Medicaid, and the State as negotiated with the CMS-RO. (See §4514.)

E. Other Direct Costs - Enters estimates for these categories as developed in the narrative justification. (See §4611.)

F. Total Direct Costs - Automated system adds lines 3 and l5 of the appropriate column.

G. Indirect Costs - Enters the rate and the base against which the rate is charged. (See §4611.) Expenditures included in this category must not be duplicated under direct costs.

H. Total Budget Request - Automated system totals lines 16 and 17 and enters the Total Costs in Line 19.

I. Certification: Date, Signature, and Title - The automated system enters the date for budget request. In the signature space, the SA's certifying official types their name and title.

4627 - Preparation of the State Survey Agency Certification Workload Report - Form CMS-434 (Exhibit 52)

(Rev. 1, 05-21-04)

The SA is required to prepare a planned workload report to accompany its budget request for survey and certification activity. The SA:

A. Column (A), Facility Counts

Enters the projected number of facilities at the start of the FY for each facility type listed under column titled Type of Provider.

B. Column (B), Initial Visits

Enters for projected facility type, the number of visits for initial certification surveys.

C. Column (C), Resurvey Visits

Enters for projected facility type, the number of visits for recertification surveys.

D. Column (D), Follow-Up Visits

Enters for projected facility type, the number of visits that the SA makes as a result of finding deficiencies in initial, resurvey, and complaint visits to providers.

E. Column (E), Complaint Visits

Enters for each facility type, the number of visits the SA makes to investigate complaints from beneficiaries, facility staff, etc.

F. Column (F), Total Visits

The automated system totals each facility type, the cumulative number for items, columns B through E.

G. Certification

Form CMS-434 must be certified by an appropriate SA official by typing their name and title in the appropriate space.

4628 - Preparation of Budget Request

(Rev. 1, 05-21-04)

A. List of Materials and Order of Assembly

The SA assembles the budget documents in descending order, as follows:

1. Form CMS-435 and Form CMS-434;
2. State Agency Budget List of Positions, three Forms CMS-1465A;
3. State Agency Schedule for Equipment Purchases, three Forms CMS-1466;
4. The justification arranged in line item order;
5. Any bulky exhibit referred to in the line item justification; and
6. Supplemental documentation as requested in the annual budget call letter.

B. Routing

The SA certified documents are made available to RO and CO in accordance with the due date provided by CO. This will ensure that CMS can complete the budget approval process in time to prevent interruption to cash flow when one FY ends and the succeeding FY begins. The request supporting title XIX SNF/NF, NFs, and ICF/MR workload (forms and narrative justification) should have the concurrence of the SMA. All additional documentation that was requested in the annual budget call letter should be sent the CO/RO.

4629 - Developing Budget Recommendations - RO Procedures

(Rev. 1, 05-21-04)

It is the RO's responsibility to ensure that only necessary and reasonable funding is approved. In negotiations and final recommendations of the SA's budget and planned workload, it is important to ensure that the SA has a full understanding of established CMS policies. The following items are to assist the RO in the final recommendations of the SA's budget.

A. Base Data

The number of facilities the SA is required to survey and the staff-years required to accomplish the survey activity is the basis for approving the line item budget. These include any additional workload projected in the ensuing FY, e.g., newly-established

provider expenditures for the 12-month period ending March 31 may also serve as a guide in determining expected increases or decreases for each line item for the budget year. The RO will inform the State that funds provided as a result of the budget approval can only be used for the necessary expenses in carrying out the survey and certification activity.

B. Significance of Categorical Budget Recommendations

The budget recommendation is a detailed concurrence or revision to State estimated survey program costs. The RO negotiates the budgets by line item, according to the category of the proposed expenditure. The RO explains the adjustment of any category with respect to program objectives and the methods used to compute each amount.

The CMS places strong emphasis on training of State surveyors. Therefore, the budget approval must include the request that States not reprogram training funds without prior RO approval.

C. Line Item Justification

The projected workload, together with the impact of expected program developments and emphasis, the SA's own plans, and the experience of the 12-month period ending March 31 are the primary factors to consider when approving the line item budget. The RO considers these factors in its approval of the SA's budget request. The rationale for any change by the RO of the State's proposal should where possible:

- Show the revised estimate;
- Explain the rationale for the change; and
- Provide the basis for computing the revised estimate.

D. State Agency Budget List of Positions (Form 1465(A) - RO Recommendations

The RO will review and validate the list of positions to determine if the staff-years and salary costs reported on Form CMS-435 are correct. A limit on the number of full-time equivalents chargeable to the Federal program budgets will be set by the RO. The RO is responsible for monitoring all staffing and analyzing State requests and requirements for additional support staff. No costs associated with the NAR/NATCEP are to be included on this form. All costs relating to NAR/NATCEP are to be reported as Miscellaneous, line 14A. (See §4543.)

E. State Agency Schedule for Equipment Purchases (Form CMS-1466) - Recommendations

This form has a two-fold purpose: It is used when requesting budget approval of equipment purchases, and it is to be completed and notification given to the RO when an

actual purchase is completed. The RO reviews the list for the necessity of items requested, comparing it to inventories of the State's existing equipment.

4630 - Notification of Approval

(Rev. 1, 05-21-04)

A. Explanation of State Survey Agency Budget Notice of Approval, Form CMS-435 (Exhibit 45)

This form is used to notify SAs of the amounts approved for the FY. It is the same form as the budget request, hence, no explanation of the entries is necessary.

B. Notification of Availability of FFP

ROs recommendation State estimated FFP Medicaid requirements on the same budget form (Form CMS-435) which the State provides to estimate State and Federal financial requirements. Since this is the same form, no explanation of the entries is necessary. The annual approval for Medicaid is for planning purposes and is non-binding. State-provided quarterly estimated requirements and actual expenditures are the final determinants for Medicaid funding. These requirements are covered under §4636.

C. Line Item Limitation on Use of Funds

To provide flexibility to the SA, line item controls are generally not placed on amounts approved for a FY, with the exception of training. However, under certain circumstances, specific controls may be imposed on expenditures through the comments attached to the budget approval documents.

D. Due Date

The CO will forward notice of budget approval to the RO who in turn will forward the original documents to the State Agency.

The RO assembles the budget documents as follows:

- Three Forms CMS-435;
- Form CMS-434;
- Form CMS-1465A. Separate forms are required for Medicare non-LTC and LTC and Medicaid LTC;
- Form CMS-1466; and
- Other documentation as required in the annual budget call letter.

4636 - RO Distribution of Approved Funds

(Rev. 1, 05-21-04)

The RO forwards the SA's recommendation funding to CO for processing. The CO is responsible for the execution and oversight of the SA's approved Medicare and Medicaid budgets for survey and certification activity.

The CO prepares an internal document quarterly for each SA with an approved Medicare title XVIII budget authorizing funds upon which the State may draw. The amount is one-fourth of the SAs approved budget. This information is forwarded to the Division of Accounting (DA) in CMS for processing. The DA enters the authorization in the Payment Management System. (See §4636.1.)

Medicaid title XIX quarterly grants are prepared and issued to States with approved plans for survey and certification activity in accordance with 42 CFR Part 430.30. The amount of a grant is based on documents provided to the CMS-RO (estimate of Federal funds required with certification of States matching funds available and prior quarter actual expenditures). The CMS-RO reviews and approves the certified documents and provides notification to CMS-CO for processing. CO prepares a computation worksheet and two-page grant award letter authorizing the release of funds to the SA. The original award is mailed to the SA and a copy is forwarded to the DA in CMS for entry into the Payment Management System.

4636.1 - Disbursement of Approved Funds

(Rev. 1, 05-21-04)

The Public Health Service (PHS), Office of Resource Management, Division of Payment Management is responsible for the disbursement and tracking of Medicare and Medicaid survey and certification funds. As CO authorizes funding levels, they are entered into the automated Payment Management System for SAs to draw upon as funds are needed. Each SA interacts directly with the Division of Payment Management in the disbursement of funds.

The SA should address any questions regarding policies and procedures to be followed regarding the disbursement of Federal funds as follows:

Health and Human Services
Program Support Center
Financial Management Services
Division of Payment Management
Post Office Box 6021
Rockville, Maryland 20852

(301) 443-1660

4640 - Need for Additional Title XVIII and Title XIX Funds

(Rev. 1, 05-21-04)

At the end of each quarter, the SA should analyze current rate of expenditures for the title XVIII non-LTC and LTC survey activities. The SA advises the CMS-RO as soon as possible if a supplemental budget may be necessary. State Agencies should take full advantage of line-item flexibility (see §4630) to stay within their approved budget before requesting additional funding.

Supplemental budget requests are not necessary for title XIX survey and certification activities. The SA will be paid at the appropriate FFP rate for the necessary and reasonable costs incurred during the FY for survey and certification activities relating to Medicaid title XIX.

4640.1 - Title XVIII Supplemental Budgets

(Rev. 1, 05-21-04)

The SA is requested at the direction of the CO or RO, to review Medicare title XVIII non-LTC and LTC survey activity requirements for the balance of the FY. If additional funds are required, the SA prepares and sends a supplemental budget request memorandum to the RO. The memorandum should include the total amount of supplemental funding required and detailed justification supporting the request. The SA should allow sufficient time for the RO to review, provide recommendation, and notify CO for processing of the supplemental budget request. Please note that CO will make all final decisions regarding supplemental budget requests. Furthermore, the limit on expenditures for a FY is the SA's approved budget. Any expenditures reported on the cumulative Form CMS-435 above the approved budget amount will be treated as a supplemental request. All supplemental funding is subject to availability of funds.

4642 - RO Monitoring of SA Fiscal Budgets

(Rev. 1, 05-21-04)

It is the responsibility of the RO to monitor the SA's performance in adhering to the policies and established guidelines. Specific instructions are provided to the SAs regarding the fiscal management of the funds provided for survey and certification activities.

A. Mid-Year Review

The RO advises the SAs to review their rate of expenditures to ensure that the Medicare title XVIII budget approval will not be exceeded. (See §4712.) Funds that exceed the SA's approved budget at the end of the FY may not be paid.

B. Supplemental Budget Requests

At the direction of the CO, the ROs should instruct the SAs to review their fiscal requirements for the balance of the FY. If it appears that additional funds will be required, the SA should prepare a supplemental budget request. The request for additional funding must be prepared in the same manner as the initial SA budget request, on Form CMS-435. The RO analyzes the State's request and provides a recommendation for approval to CO for supplemental funding subject to the availability of funds.

C. Medicare Fiscal Year Cumulative Report (Form CMS-435)

The SAs are to prepare and certify a cumulative FY title XVIII Medicare expenditure report no later than 60 days after the close of the FY and provide notification to the RO. A cumulative expenditure report for the Medicaid program is not required.

D. NAR/NATCEP

The State is required to conduct these activities as part of its §1864 Agreement as authorized by §1864 of the Act. Refer to §4543 for the allowable expenses. The Survey and Certification Program does not pay expenses incurred for the training of nurse aides.

E. State Licensure Costs

The CMS' policy is that total survey costs must be allocated to each benefiting program or activity to determine the payable costs for that program or activity. Knowledge of the State's licensure requirements is necessary in negotiating the budget to ensure that the State's share is equitable and in line with current policy. For example, if a Medicare survey covers 100 standards and the State has adopted 50 of these standards as licensing standards, Medicare would cover 100 percent of the survey costs of the 50 Medicare-only standards and the State and Medicare would equally share the survey costs of the other 50 standards. If the State has any non-Medicare standards, the State must bear 100

percent of the survey costs for those standards. For requirements common to all three programs, the State must pay two-thirds of the survey costs (representing the allocation to State licensure and Medicaid), but receives FFP in the Medicaid one-third share.

F. Cost Sharing for Title XVIII/XIX Facilities

As stated in subsection E above, it is the RO's responsibility to ensure the proper distribution of costs is made by the SA. The RO informs the States of CMS' policy concerning this issue. The SAs may not deviate from this policy. The costs of a survey for a title XVIII/XIX facility must be shared equally between Medicare and Medicaid (FFP applicable to title XIX) regardless of the number of beds assigned to each program. The requirements are the same for both Medicare and Medicaid. Consequently, both programs benefit from the survey.

Financial Accounts and Reporting

The following instructions are provided to assist the SA in the preparation of the Form CMS-435 and Form CMS-434. Please review §§4700 through 4766.

4700 - SA Accounts

(Rev. 1, 05-21-04)

It is the responsibility of the State to ensure that all estimates and reports of expenditures and other reports are prepared timely and in accordance with appropriate budgetary and accounting methods and administrative practices adopted by DHHS.

It is the desire and intent of CMS to accept State practice in the manner in which funds received from the Federal government are handled and accounted for, and in a State's choice of a depository, subject to the general accountability required under Article IX, Cost of Administration, of the §1864 Agreement. However, funds advanced to a State must be identifiable in a State's records. This is usually achieved by use of a separate account. The policies and instructions established by CMS for States' receipt of funding advances and submission of reports have been drafted with a view to following State patterns to the fullest extent possible.

4701 - Supports for SA Expenditures

(Rev. 1, 05-21-04)

The SA must provide, through its accounting and statistical records, support for all expenditures incurred in connection with survey and certification. No particular kind of accounting record, method, or procedure is required, but the State's accounting records and supporting documents must be such as will permit verification by Federal fiscal audit and CMS administrative review of all charges and of the status of advances made to the State.

If a State is receiving grants-in-aid administered by DHHS in connection with its regular program, the accounting and procurement methods and procedures described in the agency's approved plan for such grant-in-aid program are applicable with respect to the agreement to the fullest extent possible.

The State is responsible for securing necessary data from its local or district offices, and ascertaining the validity of all data for budgetary and other purposes.

4710 - SA Financial Reporting

(Rev. 1, 05-21-04)

Beginning in FY 2002, the financial reporting process requires the electronic preparation of all budget requests for State Survey and Certification and CLIA funds through the automated reporting system. The SA prepares a Form CMS-435 for budget submission, supplemental budget requests, and to report quarterly actual expenditures for both the Medicare and Medicaid survey and certification program. The SA indicates the specific use by checking the appropriate box at the top of the form. The year-end cumulative expenditure report for Medicare must also be prepared on Form CMS-435. This form is a multi-purpose, multi-program form designed to capture funds requested, approved by the RO, and expended by the SA for survey and certification activity.

4711 - Cash Basis

(Rev. 1, 05-21-04)

The method of financial reporting recommended is the "cash basis." Thus, the data will be based upon "cash accounting" which requires that charges against CMS funds be entered on the SA books when the formal vouchers (or other documents that are accepted by the State fiscal office for payment) are prepared for transmission to the State fiscal officer for payment.

4712 - SA Limit on Expenditures

(Rev. 1, 05-21-04)

The total amount approved in the State's Medicare title XVIII annual approved budget at the end of the FY shall be the limit on expenditures. The title XIX estimated annual budget is for planning purposes only. The SA is paid the FFP rate for the reasonable and necessary costs incurred for survey and certification activity.

4714 - Periodic Analysis of Accounts

(Rev. 1, 05-21-04)

Since title XVIII survey and certification total expenditures for a FY may not exceed the amount approved for that period, the SA should review the status of accounts not less frequently than once each quarter. This allows observation of expenditure trends in order to avoid over-expenditure or the unrecognized accumulation of a large amount of un-liquidated obligations, and also provide early identification of any need for supplemental funds.

4716 - Cash Balances and Expenditure Authority

(Rev. 1, 05-21-04)

Unexpended funds on hand in the agency at the end of each quarter will be available for expenditure in the succeeding quarter without formal reallotment provided it is in the same FY. Funding authority for the title XVIII Medicare survey and certification activity lapses at the end of each FY. Funds cannot be carried over into the next FY. Funding for the title XIX Medicaid survey and certification activity does not lapse at the end of a FY. Unexpended funds on hand in the agency at the end of each quarter are applied to a future grant award.

4718 - Un-Liquidated Obligations

(Rev. 1, 05-21-04)

SA fiscal controls should provide current information on un-liquidated obligations. For purposes of CMS financial reporting, un-liquidated obligations are defined as bills received, but not yet prepared for transmission to the State fiscal officer for payment, and, obligations incurred for which there is acceptable evidence of a commitment or promise to pay for goods, facilities, or services in any category of expenditure, whether or not the goods or services have been received or a bill rendered.

EXAMPLE:

Equipment that had been ordered, but not paid for (whether or not received) on a semi-annual or annual basis. For example, for an item charged on an annual basis, the un-liquidated obligation reported for the first quarter of the year would represent one-quarter of the estimated annual charge. The un-liquidated obligation reported in the second quarter would represent one-half of the estimated annual charge, etc.

In preparing the Medicare title XVIII year-end cumulative expenditure report, the SA should list un-liquidated obligations on line 20 of Form CMS-435. CO will include this amount in preparing the SA year-end closeout adjustment, providing the cumulative total does not exceed the SA annual budget authority. SAs should adjust line 20 of the cumulative year end Form CMS-435 as the obligations are liquidated.

4719 - Nothing to Report on a Given Line

(Rev. 1, 05-21-04)

The SA indicates the fact that there is nothing to report on a given line by leaving the field blank. The automated system automatically enters a zero (“0”) for blank fields.

4740 - State Survey Agency Quarterly Expenditure Report, Form CMS-435, and State Survey Agency Certification Workload Report, Form CMS-434 – Preparation and Due Date

(Rev. 1, 05-21-04)

Each SA is required to prepare quarterly a Form CMS-435 (Exhibit 45) reflecting actual expenditures incurred for survey and certification activity for both the title XVIII and title XIX programs. The purpose of Form CMS-435 is to report in a categorical listing the expenditures for each quarter and to separate costs according to funding source. (See §§4760 and 4766.) A Form CMS-434 (State Survey Agency Certification Workload Report) must accompany the quarterly expenditure report. Instructions for preparing the accomplished workload are the same as for the planned workload. (See §4627.) The Medicaid State Agency must approve the title XIX expenditures before they notify the RO. The SA is required to prepare Form CMS-435/434 and notify the RO no later than 45 days after the close of each quarter.

4760 - Preparation of State Survey Agency Non-Long-Term Care Quarterly Expenditure Report, Form CMS-435 (Exhibit 45)

(Rev. 1, 05-21-04)

The purpose of Form CMS-435 (Exhibit 45) is to report in a categorical listing the expenditures for each quarter and to separate the costs according to funding source. Because Form CMS-435 is designed to capture the costs of both non-LTC and LTC expenditures by funding source, only one form needs to be prepared quarterly.

A. Heading

The SA checks the box entitled title XVIII State Quarterly Expenditure Report. The SA selects the State agency and the automated system inserts the official name for the agency, and the appropriate Region and State Code. The SA through a drop box selects the quarter and enters the year for budget period covered by the expenditure report.

B. Rounding to Next Higher Dollar

The automated system rounds expenses incurred for each line item to the next higher dollar.

C. Salaries (Non-LTC)

The SA reports staff years and salaries of both professional and clerical personnel (full-time and part-time) on duty during the reporting quarter. Staff-years to be captured here are those that relate to non-LTC activities in the Medicare program. Instructions for reporting staff years and salaries for employees are explained below. The figures

reported in this section should not exceed the number approved by the RO, except where the SA hired in anticipation of a vacancy.

How To Report Staff-Year Totals - In each category (full-time, part-time, professional, and clerical) report the actual total of staff-years worked in the Medicare program. Thus, the SA counts each employee who worked full-time in the Medicare program on non-LTC activities during the entire quarter as having worked .25 staff-years and counts a full-time Medicare employee who started or ended work during the quarter as having worked the appropriate fraction of .25 staff-years.

Similarly, the SA counts each employee who worked part-time in the Medicare program as having worked a fraction of .25 staff-years.

EXAMPLE:

If an agency has three employees, one of whom works 1/2 time in the Medicare program and two of whom work 1/4 time in the Medicare program, report total staff-years for these part-time employees as equivalent to the time worked by one full-time employee.

EXAMPLE:

1	x	1/2 x	.25	=	.125
2	x	1/4 x	.25	=	.125
Total					.250

Line 1, Professionals.

The SA enters in columns (A) and (B) the staff-years and salary costs of those professional employees who work in the Medicare program. (See instructions below on determining staff-years.)

1a. Surveyors

1b. Non-Surveyors Professional

2. Line 2, Clerical

The SA enters in column (A) and (B) the staff-years and salary costs of those employees doing work of a general clerical nature whom work with the Medicare program. Include clerical supervisors, clerks, typists, stenographers, etc. (See instructions below on determining staff-year.)

3. Line 3, Total Employees - Non-LTC

Calculated staff-years and salary costs of all employees who worked (full-time or part-time) in the Medicare program during the reporting period. These entries are the sums of Lines la, 1b, and 2, columns (A) and (B).

4. Line 4, Rate %

The SA enters the percentage used by the State to determine the level of funding for Retirement and Fringe Benefits.

5. Line 5, Retirement Contributions and Fringe Benefits

The SA enters the total of the employer's share of social security taxes, State retirement system(s) contributions and other fringe benefits.

6. Line 6, Travel

The SA enters the costs of employee travel including per diem, or subsistence in lieu of per diem, applicable to the title XVIII State survey program and does not include costs incurred for training purposes.

7. Line 7, 8, and 9, Communications, Supplies, and Office Space

The entries should include total expenditures in each of these categories for the quarter covered by the report.

8. Line 10, Equipment Purchases

This entry should be the total amount expended for equipment during the report quarter. All equipment purchases must be supported by an accompanying "State Agency Schedule for Equipment Purchases," Form CMS-1466, (Exhibit 54). (See §4614 for instructions on completing Form CMS-1466.) The SA does not include obligations for equipment on this line, but shows them on Line 20, Un-liquidated Obligations.

9. Line 11, 12, and 13, Training, Consultants, and Subcontracts

The entries should cover total expenditures in each of these categories for the quarter covered by the report. Training expenditures should include travel costs related to training.

10. Line 14, Miscellaneous

The SA enters expenditures that have not been reported in any of the preceding classifications under. The automated system sums of all miscellaneous expenditures

itemized in rows (A) through (G) on line 14. If additional space is needed, the SA submits as supplemental data the attachment explaining these items.

11. Line 15, Total Other Direct Costs.

The automated system calculates the sum of lines 5 through 14.

12. Line 16, Total Direct Costs

The automated system calculates totals lines 3 and 15.

13. Line 17, Indirect Costs for Non-LTC Workload

This figure calculated by multiplying the approved Indirect Costs rate by the negotiated money base it is applied against. (See Line 18.)

14. Line 18, Indirect Costs Rate for Non-LTC Workload

The SA indicates the rate negotiated and approved by the Director, Division of Cost Allocation and Liaison, DHHS, for use during the FY and the money base it is applied against. This official will also negotiate the money base at the same time the rate is established.

15. Line 19, Total Expenditures for Non-LTC Workload

The automated system calculates total of lines 16, and 17, Column (B). The complete quarterly expenditure report for the title XVIII Medicare program will be the total of Line 19, column (B) and (D).

16. Line 20, Total Un-liquidated Obligations

The SA enters the total obligations remaining unpaid at the end of the reporting period and itemizes all un-liquidated obligations by category (i.e., travel, office space, equipment) and submits as supplemental data.

4766 - Preparation of State Survey Agency Quarterly Expenditure Report, Long-Term Care Facility Workload, Form CMS-435

(Rev. 1, 05-21-04)

The purpose of Form CMS-435 (Exhibit 45) is to report in a categorical listing the expenditures for each quarter and to separate the costs according to funding source. Because Form CMS-435 is designed to capture the costs of both non-LTC and LTC expenditures by funding source, only one form needs to be prepared quarterly.

A. Heading

The SA checks the boxes entitled title XVIII State Quarterly Expenditure and title XIX State Quarterly Expenditures Reports. The SA selects the State agency and the automated system inserts the official name for the agency, and the appropriate Region and State Code. The SA through a drop box selects the quarter and enters the year for budget period covered by the expenditure report.

B. Rounding to Next Higher Dollar

In preparing the Form CMS-435, the automated system rounds amounts of expenses incurred for each line item to the closest dollar.

C. Report Columns

Columns are provided for reporting staff-years and line item expenditures by funding source, i.e., Medicare, Medicaid, State matching, and totals by quarter. The SA reports all costs associated with the Medicaid program in the appropriate column, and in the State matching column, those matching costs associated with the Medicaid program. The SA does enters the State licensure costs in the State column.

D. FFP (Medicaid Only)

The Federal matching share of costs for the Medicaid nursing home survey and certification program is 75 percent.

The Federal matching rate for ICF/MR survey activity is 75 percent FFP for salaries, fringe benefits, travel, and training. All other costs are matched at 50 percent.

E. Line Entries

1. Line 1a Surveyor, 1b Non-Survey Professional

The SA enters the staff-years and total Federally supported salary costs of professional employees who worked on the LTC program during the reporting quarter. (See §4760 for instructions on determining staff-years.) For Title XVIII program, the SA enters in Columns (C) and (D) the staff-years and costs related to workload, and for Title XIX program the SA enters in Columns (E) and (F) the staff-years and costs related to workload. The State share is captured in column (G). The total costs for LTC survey activity is total by the automated system in Column (H). Survey activity relating to ICF/MRs is to be entered in Columns (E), (F), and (G).

2. Line 2, Clerical

The SA follows the same instructions as for professionals and includes clerical supervisors, clerks, typists, stenographers, etc., working during the reporting quarter.

3. Line 3, Totals, Staff-Years, and Salaries (LTC)

Calculated sums of Lines 1 and 2.

4. Line 4, Fringe Benefit Rate

The SA enters the percentage used by the State to determine the level of funding for Retirement and Fringe Benefits.

5. Lines 5, Retirement/Fringe Benefits

The SA enters the total of the employer's share of social security taxes, State retirement system(s) contributions, and other fringe benefits.

6. Line 6, Travel

The SA enters the cost of travel, including per diem or subsistence in lieu of per diem and charges all travel for the LTC program in accordance with provisions of State law, regulations, and administrative procedures applicable to travel of State employees. The SA does not include in this section travel cost incurred for training purposes.

7. Line 7, 8, and 9, Communications, Supplies, and Office Space

The entries should cover total expenditures in each of these categories for the quarter covered by the report.

8. Line 10, Equipment

This is the amount expended for equipment during the reporting quarter. All equipment purchases must be supported by an accompanying "State Agency Schedule for Equipment Purchases," Form CMS-1466. (See instructions in §4614 for completing Form CMS-1466.) The SA does not include obligations for equipment.

9. Lines 11, Training

The SA enters the cost of training SA personnel. Training expenditures should include travel costs related to training.

10. Line 12 and 13, Consultants and Subcontracts

The SA enters total expenditures in each of these categories for the quarter covered by the report.

11. Line 14, Miscellaneous

The SA enters expenditures which have not been reported in any of the preceding classifications under Miscellaneous and enters all costs incurred for maintenance of the NAR and the NATCEP in line 14A under Miscellaneous. This should include salaries, fringe benefits, indirect costs and any other expenses incurred to maintain the NAR and NATCEP. The automated system sums of all miscellaneous expenditures itemized in rows (A) through (G) on line 14. If additional space is needed, the SA submits as supplemental data the attachment explaining these items.

12. Lines 15, Total Other Direct Costs

Calculated sum of lines 5 through 14.

13. Lines 16, Total Direct Costs

Calculated total of lines 3 and l5.

14. Lines 17, Indirect Costs for LTC Workload

This figure is derived by multiplying the approved Indirect Costs rate by the negotiated money base it is applied against. (See Line 18.)

15. Line 18, Indirect Costs Rate for LTC Workload

The SA indicates the rate negotiated and approved by the Director, Division of Cost Allocation and Liaison, DHHS, for use during the FY and the money base it is applied against. This official will also negotiate the money base at the same time the rate is established.

16. Line 19, Total Expenditures for LTC Workload

Calculated total of lines 16 and 17, Column (D). The complete quarterly expenditure report for the title XVIII Medicare program will be the total of Line 19, column (B) and (D).

17. Line 20, Total Un-liquidated Obligations

The SA enters the total obligations remaining unpaid at the end of the reporting period and itemizes all un-liquidated obligations by category (i.e., travel, office space, equipment) and submits as supplemental data.

18. Certification: Signature, Title, and Date

For the Form CMS-435s, the automated system enters the date and the SA certifying official types their name and title.

4766A - Preparation of State Survey Agency Quarterly Expenditure Report, MDS, Form CMS-435

(Rev. 1, 05-21-04)

The SAs are to complete Form CMS-435 (see Exhibit 45) State Survey Agency Budget/Expenditure Report for costs associated with MDS. Form CMS-435 is a multi-purpose (budget request and approvals, reporting expenditures, supplemental funding request, etc.) form used in Medicare and Medicaid applications. Its various uses are displayed at the top of the form. The SA indicates the specific use of the form by following the same guidance provided for a standard Form CMS-435. These forms summarize requested funding levels for each category of expense.

4766B - Preparation of State Survey Agency Quarterly Expenditure Report, OASIS, Form CMS-435

(Rev. 1, 05-21-04)

The SAs are to complete Form CMS-435 (see Exhibit 45) State Survey Agency Budget/Expenditure Report for costs associated with OASIS. Form CMS-435 is a multi-purpose (budget request and approvals, reporting expenditures, supplemental funding request, etc.) form used in Medicare application. Its various uses are displayed at the top of the form. The SA indicates the specific use of the form by following the same guidance provided for a standard Form CMS-435. These forms summarize requested funding levels for each category of expense.

4767 - Initial Survey Activity Reports

(Rev. 1, 05-21-04)

The CMS CO has requested that SAs prepare and submit, on a quarterly basis, the initial survey activity being performed by the State agencies. The ROs designed the "Report on Initial Survey Activity" (Exhibit 216) and the "Aging Report on Pending Initial Survey Activity" (Exhibit 217), to be prepared by each State agency. Instructions for completion of these two forms are as follows:

4767A - Preparation of Report on State Initial Survey Activity

(Rev. 1, 05-21-04)

Usage

The "Report on Initial Survey Activity " is used to record initial surveys requested by prospective Medicare providers in each State.

Heading

Insert the State for which the information is being reported. Enter the quarter ending date for which the activity is being reported.

Definition of a Pending Initial

A pending initial is one in which a prospective provider of care has requested and is ready for a survey. The prospective provider must also have in place the tangible assets necessary to do business, such as a facility, equipment, etc., and have submitted an application to become a Medicare provider.

Column A, # of Pending Initial Surveys at Start of the Quarter

Enter for each facility type the number of pending initial surveys that were not completed at the beginning of the report period.

Column B, # of Initials Requested for the Quarter

Enter for each facility type the number of initial surveys that have been requested by a prospective provider for the current quarter.

Column C, # of Initials Completed for the Quarter

Enter for each facility type the number of initial surveys that were completed (i.e., a survey was performed) for the current quarter being reported.

Column D, # of Initials Completed Year to Date

Enter for each facility type the number of initial surveys that were completed (i.e., a survey was performed) beginning with the current fiscal year through the current reporting period.

Column E, # of Applications Withdrawn for the Quarter

Enter for each facility type the number of initial applications that were withdrawn (i.e., prospective providers that requested an initial survey but withdrew their request before being surveyed) for the current quarter being reported.

Column F, # of Pending Initials End of Quarter

Enter for each facility type the number of initial surveys remaining at the end of the current quarter. This number must be obtained by adding Column A and Column B and subtracting Column C and Column E.

4767B - Preparation of Aging Report on Pending Initial Survey Activity

(Rev. 1, 05-21-04)

Usage

The "Aging Report on Pending Initial Survey Activity" is used to record the number of days an initial survey is pending for each State by facility type.

Reconciliation

The number of pending initials as reported in column "H" on the "Report on Initial Survey Activity" must reconcile to the aggregate number of pending initials that are aged on the "Aging Report on Pending Initial Survey Activity."

Column A, 0 - 30 days

Enter for each facility type the number of pending initials that are outstanding 0 to 30 days.

Column B, 31 - 60 days

Enter for each facility type the number of pending initials that are outstanding 31 to 60 days.

Column C, 61 - 90 days

Enter for each facility type the number of pending initials that are outstanding 61 to 90 days.

Column D, 91 - 120 days

Enter for each facility type the number of pending initials that are outstanding 91 to 120 days.

Column E, Over 120 days

Enter for each facility type the number of pending initials that are outstanding over 120 days.

Section 1864/Section 1903(a) Fiscal Audits

4780 - Scope of Audit

(Rev. 1, 05-21-04)

Occasionally, auditors for the DHHS regional OIG Office of Audit Services (OIG/OAS) audits each SA certification program to determine that:

- The SA has properly reported its accountability of Federal program funds;
- No Federal program funds were used for any purpose contrary to the §1864 agreement, applicable State and Federal laws and regulations, or CMS financial administration standards;
- The share of the Federal government in any miscellaneous receipts was properly credited on the books of the SA and reported to CMS.

4781 - Objectives of Audit

(Rev. 1, 05-21-04)

The objectives of the audit of receipts and expenditures are to determine that:

- Vouchers are mathematically correct, supported by substantiating documents, and in agreement with entries in the records;
- Expenditures for which charges are made against the certification program are properly authorized, approved, and made in accordance with Federal and State laws, rules, regulations, and the §1864 agreement;
- Expenditures are properly classified between the certification program and other programs of the SA;
- Expenditures are actually disbursed in the correct amount to the proper payees;
- Refunds or credits are properly accounted in computing the amount of the charges against Federal funds; and
- The agency properly reports its accountability for Federal funds.

The SA expenditures are audited on the basis of standards in effect at the time they were made or incurred. The State is given a full explanation of any questioned items and afforded a reasonable length of time to explain them.

4782 - Records to Be Reviewed

(Rev. 1, 05-21-04)

All records required establishing the auditors may examine the correctness of an SA's claim for Federal funds. The SA should be prepared to furnish not only those data usually considered as the formal accounting system, but also any other agency records which may contain information necessary to establish the facts. This may include the accounts and records of State fiscal officers, if they involve receipt, custody, and disbursement of Federal funds, and the records of other State agencies where necessary to substantiate claims made against Federal funds.

4784 - RO Role During Audit Process

(Rev. 1, 05-21-04)

4784A - Pre-Audit

(Rev. 1, 05-21-04)

The RO provides assistance to HHS auditors who visit the office to:

- Interview RO staff to identify specific fiscal and certification problem areas and the corrective action taken or planned, or to review certification workflow and procedures for assuring SA compliance with title XVIII/XIX certification provisions;

- Review RO records such as recent trip records, program review reports, validation survey findings, budget files, etc.;

- Examine the working relationship between the RO and the SA; and

- Analyze certification files in the RO instead of in the SA.

4784B - During Audit

(Rev. 1, 05-21-04)

The RO has only an advisory role in the performance of the audit fieldwork. It can answer program policy questions that surface during the audit, provide needed technical advice to auditors, and interpret instructions and guidelines. The RO may be called upon

by the OIG/OAS to participate in advance discussion of the audit if audit findings clearly warrant immediate corrective action, and to initiate needed action without waiting for the final audit report.

4784C - At Exit Conference

(Rev. 1, 05-21-04)

The regional OIG/OAS will notify the RO of the date of the exit conference with the SA at least 10 days in advance. RO representation at the conference is optional insofar as the OIG/OAS is concerned; however, RO attendance provides an opportunity to hear both sides and to contribute the RO viewpoint prior to the final report. An exit conference between the auditors and SA officials explains informally what the auditors' intent to report and serves to clear up misunderstandings before the audit report is drafted.

4785 - Draft and Pre-Release Audit Report to RO

(Rev. 1, 05-21-04)

Where findings are made, the auditors will issue a draft audit report and send it to the SA for comments. Like the audit exit conference, the draft report provides the SA with an opportunity to furnish comments and information that will eliminate inaccuracies and misunderstandings from the final report.

When significant findings are made, OIG/OAS will prepare a "proposed final report" or "pre-release report" which it sends to the RO with a request for written comments. The report is normally accompanied by the State's comments from the draft report. This procedure provides an opportunity for the RO to have those recommendations that are not complete, not legally enforceable, or otherwise difficult to clear removed before the final report is released. The RO uses the pre-release procedure as a means of obtaining audits with complete recommendations that are readily clearable within the required 6 months.

The RO should submit comments on the proposed final report to the audit agency within 30 days of the issuance of the report using a form called a "pre-release notification document" (PND). (See Exhibit 218.) The RA must either concur or nonconcur with each finding and recommendation in the report, providing the reason in the event of nonconcurrence. When the RA signs the PND, the RO sends it to the originating regional OIG/OAS official. Copies of the PND are sent to all parties on the report distribution schedule.

4786 - Final Audit Report and Final Determination - RO Procedures

(Rev. 1, 05-21-04)

4786A - General

(Rev. 1, 05-21-04)

The final audit report is distributed by the regional OIG/OAS in accordance with its distribution list. If the SA accepts the findings and recommendations, the SA's signed agreement must be obtained by the RO. If the SA disagrees, the RO will issue a formal written determination. (See §4792 for disallowance notifications.) The determination should be made at the point when the RA can see the unlikelihood that an agreement will be reached with the SA on the audit recommendations, in order to clear the audit within the 6-month period required by law.

4786B - Timeliness of Final Audit Resolutions

(Rev. 1, 05-21-04)

In accordance with P.L. 96-304, RAs are required to resolve (clear) audit findings within 6 months of the date of issuance of the final audit report by the OIG/OAS. For this purpose, resolution is deemed to occur when a final decision on the amount of any monetary recovery has been reached and communicated to the auditee; a satisfactory plan of corrective action, including time schedules, to correct all deficiencies has been established and communicated to the auditee; and the report has been cleared from the Department's tracking system by submission and acceptance of an audit clearance document (ACD).

To resolve difference and obtain full information upon which to base a decision or obtain a settlement, the RA may consult with the SA and the auditors either before or after the SA reply. This is a fact finding rather than a negotiating step. It does not delay public access to the final audit report, which is made available for public inspection 30 days after it is issued to the State.

4787 - RO Review of SA Response

(Rev. 1, 05-21-04)

4787A - Contacting SA

(Rev. 1, 05-21-04)

The letter transmitting the final audit report to the SA either advises the SA to respond to the RA within 30 days regarding the findings in the report or advises that CMS will

contact the SA. In either case, the RO will promptly contact the SA and, as appropriate, remind it to respond, request any needed information, and offer an opportunity for the SA to provide any further information on the report. The SA's response should provide the following information:

- Specific concurrence or nonconcurrence with each finding and recommendation;
- A description of the specific actions taken or planned (including time schedules) to correct each deficiency, if it agrees that a deficiency(ies) exists; and
- Specific reasons for each nonconcurrence.

4787B - Timely Response

(Rev. 1, 05-21-04)

The RO must maintain controls indicating the due date of the SA response, and immediately contact the SA if the date is not met. The RO should emphasize the importance of timely responses to audit reports and follow up if a response is not complete as described in subsection A. Where justified, an extension of time for the submission of the response may be granted by the RO. However, such extensions will not extend the 6-month due date set out in §4786.B.

4787C - Consideration of Supporting Arguments and Information

(Rev. 1, 05-21-04)

The RO should accord full and fair consideration to any arguments and information submitted in support of the SA's position. However, the SA should exercise caution in evaluating information that conflicts with information contained in the audit report or documentation that was not provided to the auditor. When such information is significant, the RO can discuss it with the auditor and, where necessary, refer it to the auditor for review and comments.

4787D - Agreements and Disagreements

(Rev. 1, 05-21-04)

If CMS finds that nonallowable costs have been charged to Federal awards and the State agrees with the finding, the agreement is confirmed in a letter from the RA to the State director, who signs and returns a copy of the letter to CMS. This letter constitutes the initial notification to debtors of the United States as required by the Federal Claims Collection Standards (42 CFR 102.2). Interest is charged in accordance with Federal claims collection standards.

If the SA disagrees with the CMS finding, the RA will make a unilateral final determination, notify the SA of the amount that is unallowable, and advise of the right to appeal. (See §4788.) The CMS notification also includes information on the appeal procedure.

4787E - Program Findings and Recommendations

(Rev. 1, 05-21-04)

Audit reports may fault SA management practices or fault the degree and manner in which the State carries out its responsibilities under applicable statutes and regulations. Although OIG/OAS maintains control of program findings that have significant monetary implications and require certain "safeguard" measures to be taken, implementation of recommended corrections of program findings is primarily the responsibility of CMS.

Whereas the repayment of funds may be thought of as a retrospective correction, elimination of deficient program management practices is prospective. The SA and CMS must agree upon and specify appropriate corrective actions and a time schedule for completion, which CMS follows up on in the course of subsequent management monitoring activities. Frequently, the auditor may accompany CMS representatives to meetings with the State to clarify what correction is needed. Problems may be subject to follow-up by OIG/OAS as well. In order to clear the audit, the RA must be able to advise OIG/OAS that agrees to how and when the problems will be satisfactorily corrected.

4788 - SA Disallowance Appeals

(Rev. 1, 05-21-04)

The appeals for Medicare and Medicaid disallowances are discussed in §§4788.1 and 4788.2.

4788.1 - Medicare Disallowance Appeals

(Rev. 1, 05-21-04)

To the extent that a dispute relates to the cost of the SA's activities pursuant to §1864 and the §1864 agreement, there is a right to appeal to the Armed Services Board of Contract Appeals in accordance with the Contract Disputes Act, 41 USC 607.

In the event the SA elects to appeal title XVIII issues under the Contract Disputes Act, the SA must mail or otherwise furnish written notice of appeal to the Armed Services Board of Contract Appeals within 90 days from the date of the Medicare disallowance, as instructed in the disallowance notice. Also, the SA mails a copy of such notice to the RO.

The Contract Disputes Act also affords the SA the option to bypass the appeal process entirely by bringing an action directly to the U.S. Court of Claims within 12 months of the date of the Medicare disallowance.

4788.2 - Medicaid Disallowance Appeals

(Rev. 1, 05-21-04)

When it is determined by the RO that a State claim for FFP in Medicaid expenditures for a particular item or class of items is not allowable, the RA issues a disallowance letter to the State. A Medicaid disallowance action may be initiated based upon a review of a variety of information, such as the Form CMS-435, audit report findings, or a financial review.

The SA will receive one of three letters based on the type of Medicaid disallowance determined:

- A regular disallowance letter. (See Exhibit 58.);
- A deferral disallowance letter (see Exhibit 59) and, if necessary, a subsequent disallowance letter for amounts previously deferred. (See Exhibit 60.); or
- An audit disallowance letter. (See Exhibit 61).
- After receipt of a disallowance letter, the SA has two options in order to resolve the Medicaid disallowance action:
- Concur with the Medicaid disallowance and take appropriate action to resolve it by adjusting the next quarterly expenditure report for the disallowed amount; or,
- Appeal the action to the DAB via State appeal rights outlined in each disallowance letter.

4789 - RO Documentation of Agreements on Actions to Correct Audit Deficiencies

(Rev. 1, 05-21-04)

When an agreement on the corrective actions is reached, the RO must confirm the agreement in a letter to the responsible SA official. The RA must sign this letter, and the recipient State official must sign and return a copy of the letter to the RO. If an agreement is reached on corrective actions for some but not all of the deficiencies, the letter should cover the agreed-upon actions. All agreements on corrective actions must, at a minimum, include the information described below:

- The specific actions taken or planned to correct each deficiency. Describe these actions in sufficient detail to permit a subsequent determination of the SA's compliance with the agreement;

- The date(s) the actions have been or will be implemented;

- Reference to any implementing policies, procedures, or forms, or a requirement that they be submitted by a specific date; and

- Requirements that the organization obtain the RO's advance approval of any modifications to the agreement.

4790 - General Rules on Cost Allowability - RO Procedures

(Rev. 1, 05-21-04)

4790A - Cost Allowability

(Rev. 1, 05-21-04)

Except as otherwise provided in section B, all decisions to allow or disallow costs must be based solely on whether they are allowable or unallowable under the regulatory cost principles and provisions of the budget approvals. RAs have responsibility and authority (subject to appeal) for determining whether costs are allowable or unallowable and for determining the dollar amount of any unallowable costs. In making these determinations, RAs have some discretion on matters of interpretation. However, such discretion does not include the authority to ignore applicable laws, regulations, or policies or authoritative interpretations issued by the courts, GAO, OGC, responsible policy offices, or other appropriate authorities.

- For any audit finding in which the auditor has recommended an adjustment exceeding $100,000, the CMS Administrator or Deputy Administrator must give prior written approval for any settlement which is less than 85 percent of the amount recommended by the auditor.

- In the resolution of the findings, a clear distinction must be made between the determination of whether a cost is allowable or unallowable and the actual collectability of a disallowance. If a determination is made that a cost is unallowable, the RA does not have the authority to "waive" collection of the disallowance. Disallowances constitute claims by the Government and may be waived or reduced only by CMS' claims collection officer under limited conditions prescribed in the Federal Claims Collection Act (P.L. 89-508), the Debt Collection Act of 1982 (P.L. 97-365), and implementing procedures described in the CMS Administrative Issuances System chapter on financial management.

- In determining whether a cost is allowable or unallowable, the RO cannot use factors such as the good faith of the State, its successful accomplishment of program objectives, or it's ignorance of the provisions of the budget approval process as a basis for allowing costs which are unallowable under the provisions of the budget approval.

4790B - Exceptions to Cost Allowability Rules

(Rev. 1, 05-21-04)

As stated in §3150, the decision to allow or disallow a cost must be based on whether it is allowable under the provisions of applicable regulations and the budget approval. There are two situations, however, where an exception to this rule may be permitted:

1. If a transaction requiring prior approval under the provisions of a budget letter or the SOM is questioned because the approval was not requested, the transaction may be approved retroactively, assuming that funds are available. Retroactive approvals may be granted, however, only where:

    - The transaction would have been approved had the State requested it in advance; and

    - The State agrees to institute controls to ensure that prior approval requirements are met in the future; or,

2. In exceptional cases where strict adherence to an original provision of an award would result in a clear inequity to the State, the provision may be waived.

These exceptions are to be used in extraordinary situations when adherence to cost allowability rules would result in a serious inequity. The provision to be excepted must not be one mandated by law. The RO should request OGC concurrence that the proposed exception is legal and acceptable to OGC. If OGC concurs, The RO may proceed to fix the amount of overpayment. Thoroughly check all pertinent regulations and policies in 45 CFR Part 74, in the HHS Grants Administration Manual, and in other guidelines, to assure proper handling of any deviation from standard procedures. Note that if the auditors' recommended adjustment was over $100,000, a settlement for less than 85 percent requires approval by the Administrator or Deputy Administrator.

4790.1 - Determinations of Overpayment - RO Procedures

(Rev. 1, 05-21-04)

It is essential that overpayments be determined separately for each fiscal year involved. This is true even if estimates are used as in §4790.2.

In some cases a sustained audit disallowance is not an overpayment debt to be collected by the U.S. Government. An auditor and the audit action official may determine that a particular claimed expenditure is not allowable. However, it is possible the auditee had never received cash withdrawal from the Department Federal Assistance Financing System for the disallowed expenditure. While the expenditure was "disallowed" via the audit resolution process, it would not be an overpayment since the State had never requested nor received an actual

Federal payment for the expenditure that was recorded on the debtor's records. Such a situation should be clearly explained on the audit clearance document to allow CMS to properly record the amount in the accounting records.

4790.2 - Determination and Computation of Dollar Amounts - Use of Estimates - RO Procedures

(Rev. 1, 05-21-04)

In some cases, the audit report may indicate that it was not possible or feasible to identify the precise amount of unallowable costs on each award, and that an aggregate amount of the costs for all affected awards was estimated based on an analysis of a representative sample of transactions.

These estimates may be based on a valid statistical sample of the transactions, or if the use of statistical sampling was clearly impractical under the circumstances, on other reasonable and supportable estimating techniques (such as projections based on an analysis of transactions during a representative period of time). The auditor is responsible for developing estimates of any unallowable costs.

- If the SA disagrees with the use of an estimate or with the procedures used by the auditor to develop the estimate, the SA has the option of performing an alternative analysis within a specified period of time to develop more precise results. Also, the RO should follow this procedure in situations where the auditor indicates that an estimate cannot be developed, but the SA contends that it can be developed and wishes to perform an analysis to develop the estimate. If the SA elects to perform an analysis, advance agreement on the due date for submission of the analysis and the procedures to be followed in conducting the analysis so that the audit will be cleared within 6 months should be obtained by the RO. The RO and the auditor must review the results of the analysis.

- The estimates or the analysis will cover the period prescribed in the next paragraph (or will be projected to cover this period), and this amount will be used as the basis for a dollar settlement with the SA. If the parties are unable to reach an agreement within the specified time, the RA must make a unilateral determination and notify the SA of the amount that is unallowable.

- It should be noted that estimated costs (except statistically formed estimates) and costs upon which no opinion can be offered will not be coded by the OIGAA as to dollar disallowances. They may, however, require the attention of the RO to assure correction of the deficiencies in the system responsible for the situation. In this event, a management recommendation will be coded in the audit tracking system and will require corrective action and a response.

4790.3 - Time Period for Computing Disallowances - RO Procedures

(Rev. 1, 05-21-04)

If costs are disallowed as a result of an estimate or analysis, the computation of the disallowance must cover the following periods:

- If the costs can be identified to specific awards, the computation will cover the period the SA is required to retain records under applicable record retention requirements;

- If an overall organization-wide estimate is used, the computation will cover the SA's three fiscal years immediately preceding the year in which the audit started and all subsequent periods up to the date the SA changes its procedures to discontinue the unallowable charges;

- In situations involving fraud or deliberate misrepresentation by an organization, the period will be extended as far back as necessary;

- If part of the period was covered by an earlier settlement of the same issue, the period will be appropriately reduced; and

- The period may be appropriately extended in cases where a SA has submitted a retroactive claim for reimbursement of costs incurred in an earlier period, or has failed to carry out a prior commitment to take corrective action that would have prevented the problem.

4790.4 - Inability to Determine Dollar Amounts - RO Procedures

(Rev. 1, 05-21-04)

4790.4A - Supporting Costs By Alternative Means or Developing Reasonable Estimate of Unallowable Costs

(Rev. 1, 05-21-04)

As indicated above, every effort will be made by the auditors to identify or estimate the amount of any unallowable costs. In some cases the deficiencies may be so serious that costs charged to the awards cannot be supported, and it is not possible for the auditor to develop a reasonable and supportable estimate of the amount of unallowable costs. In these situations, offer the SA the opportunity to support the costs by alternative means or to develop a reasonable estimate of any unallowable costs. The RO specifies a time limit so that the audit may be resolved within prescribed time frames. If the SA submits this information, it should be evaluated by the RO and, if necessary, by the auditor to determine whether it provides a sufficient basis for allowing the costs or for reaching a dollar settlement.

4790.4B - Costs Have Not Been Supported

(Rev. 1, 05-21-04)

If the SA does not submit the information within the time limit set or if the information is inadequate or inconclusive, the RO will formally notify the SA that the costs have not been supported as required by Federal regulations. The costs are therefore disallowed, and the organization may appeal this determination. In extreme cases, the amounts involved or other circumstances may be such that this approach is impractical or inequitable. In that event, the RO should take the following steps:

1. Notify CO that the costs have not been supported and request a programmatic evaluation to determine whether the charges to the projects or programs appear reasonable in relation to the work performed.

2. Responsible program officials will perform an evaluation to determine whether the charges appear reasonable, and if they do not appear reasonable, to determine the amount of the excessive charges. To the maximum extent possible, program officials will complete the evaluation within 30 days of the RO's request. After the evaluation is completed, the results will be transmitted to the RO.

3. If the evaluation indicates that the costs appear reasonable in relation to the work performed, the costs will be allowed. If the evaluation indicates that the costs are unreasonable, the excessive amount will be disallowed.

4791 - RO Documentation of Agreements to Effectuate Repayments

(Rev. 1, 05-21-04)

The SA may agree with the auditors' findings in its response to the audit report, or the SA and RO may reach agreement only after substantial discussion regarding the amount to be adjusted. A letter signed by the RA and countersigned by the SA director (or other designated official that the State authorizes) must document any agreement. The letter must:

- Specify the method and time of repayment;
- Stipulate the amount agreed to for each audit-questioned cost item, and clearly identify what the respective cost items are;
- Set out the amounts and times of payment under an extended payment plan if it appears that the State might be unable to make repayment by the due date. (See §4791.1);
- Advise that interest on Medicare overpayments will be charged by CMS if the amount is not paid within 30 days; and
- Instruct the SA director to countersign and return a copy of the letter to the RO. (In States where an official other than the director is the only person authorized to make the financial commitment, the RO modifies the letter accordingly.)

The RO includes two signed copies so that one can be countersigned and returned. This letter constitutes the initial notification to debtors required by the Federal claims collection standards (42 CFR 102.2).

4791.1 - Repayment Not Made Within 30 Days of Agreement Letter - RO Procedures

(Rev. 1, 05-21-04)

If the State cannot agree to make repayment within 30 days from the date the RA signs the agreement letter, and this is known beforehand, the letter should note how and when payment will be made. All debts owed to CMS are to be collected timely even though CMS may owe the State offsetting funds in a different program. Consequently, it is not permissible to defer collection of a Medicare overpayment while determining whether a Medicaid underpayment might offset it, or vice versa.

If the State can demonstrate to the RO's satisfaction that severe financial hardship would occur if the entire amount of debt had to be paid within 30 days, the State does have a right to elect to repay debts (or reduce them through a series of offset actions) under an

installment plan over a maximum period of three years. In such case, however, any deferred Medicare repayment is subject to interest that the RO must periodically calculate and add to the amount remaining due. Medicaid repayments are not subject to interest charges in this situation. The minimum repayment schedule, which is mandatory for Medicaid collections, is also considered the reasonable minimum for Medicare collections:

Total repayment amount as percentage of State share of annual expenditures for the specific program	**Number of quarters to make repayment**
2.5 pct. or less	1
Greater than 2.5, but not greater than 5	2
Greater than 5, but not greater than 7.5	3
Greater than 7.5, but not greater than 10	4
Greater than 10, but not greater than 15	5
Greater than 15, but not greater than 20	6
Greater than 20, but not greater than 25	7
Greater than 25, but not greater than 30	8
Greater than 30, but not greater than 47.5	9
Greater than 47.5, but not greater than 65	10
Greater than 65, but not greater than 82.5	11
Greater than 82.5, but not greater than 100	12

The quarterly repayment amounts for each of the quarters in the repayment schedule shall not be less than the following percentages of the estimated State share of the annual expenditures for the program against which the recovery is made.

Repayment installment for each of the following quarters may not be less than these percentages:

1 to 4	2.5
5 to 8	5.0
9 to 12	17.5

If the State chooses to repay amounts representing higher percentages during the early quarters, any corresponding reduction in required minimum percentages would be applied first to the last scheduled payment, then to the next to the last payment, and so forth as necessary.

4792 - Audit Disallowance Actions - RO Notification

(Rev. 1, 05-21-04)

The following sections provide the RO with guidelines and instructions to assist in the completion of the audit process.

As soon as it is clear that agreement will not be reached expeditiously on an audit exception, the RO should make a unilateral determination of disallowance. This determination should deal only with monetary adjustments which the SA disputes. If at all possible, there should be separate earlier documents to address those financial adjustments to which the SA had agreed, remedies for audit-identified program/administrative problems, and "safeguards." The RO ensures that if there has been a prerelease notification document, there are no unreported deviations in the determination. (See §4785.)

In virtually all cases the disallowance notice must address closely intertwined Medicare and Medicaid aspects of the adjustment. However, there are slightly different notice requirements for the two programs:

- Collection and interest-charging rules are governed by Federal claim collection standards for Medicare, but are governed by §1903(d)(2) and (5) of the Act for Medicaid;

- Medicare disputes are appealed under Federal contract appeal procedures, while Medicaid disputes are appealed under grant appeal procedures; and

- If the disallowance affects Medicaid, both the SA as the auditee, and the SMA as the grantee, must be officially notified.

Consequently, it is usually necessary to prepare two separate notices. The RO should address the Medicare notice to the SA and address the Medicaid notice to both the SA and the SMA. Both should be identical up to the point where the determination is announced, but their instructions for further action differ. Exhibits 219 and 220 provide a model for the Medicaid and Medicare notices, respectively.

4792.1 - Non-Audit Medicare and/or Medicaid Disallowances - RO Procedures

(Rev. 1, 05-21-04)

When a determination is made that a State claim for Medicare survey and certification budget payment and/or FFP in expenditures for a particular item or class of items is not allowable, the RO will issue a disallowance letter to the State. A disallowance action may be initiated based upon a review of a variety of information, such as Form CMS-435

or a financial review. There must be a separate disallowance letter for the Medicare and FFP disallowances. If a Medicaid FFP disallowance is under review, the ARA consults the RO Medicaid Division for advice on regional procedures.

4792.1A - Preparation of Case File

(Rev. 1, 05-21-04)

After determining it appropriate to issue a disallowance, the RO prepares and organizes a case file, including a Disallowance Analysis Memorandum (DAM) containing necessary documentation supporting the action. (See §4793 for items comprising the records supporting disallowance actions.)

4792.1B - Assignment of File Control Number

(Rev. 1, 05-21-04)

While organizing applicable documentation, the RO assigns a unique identifying file control number to each case as follows:

- Begin the control number with a two letter State abbreviation (e.g., AL, FL, GA);
- The next series of numbers includes the current two-digit fiscal year designation (e.g., 1980 = 80, 1981 = 81); and
- The last series of numbers consists of a two-digit numerical designation (01, 02, 03, etc.), running consecutively, beginning with 01. Maintain sequential numbering series either within each State or within the region as a whole (examples: AL-80-01, FL-80-01, FL-80-02).

4792.1C - Preparation Draft Disallowance Letter

(Rev. 1, 05-21-04)

Based upon the information contained in the case record, the RO prepares a draft disallowance letter generally following the suggested format, as shown in Exhibit 219 and/or 221.

4792.1D - Circulation Draft Disallowance Action for Review

(Rev. 1, 05-21-04)

The RO circulates the draft letter and the DAM for review within the immediate responsible unit and any other necessary units and obtains clearance from the regional Counsel.

4792.1E - Signature of Disallowance Letter

(Rev. 1, 05-21-04)

Once the letter has been prepared in final format and the necessary concurrences obtained, the RO submits it through the ARA, to the RA for approval.

4792.1F - Notification of CMS

(Rev. 1, 05-21-04)

After the RA has approved the disallowance action, the RO prepares an alert to notify CO of the pending action and sends a copy of the alert, the disallowance letter, and the DAM to CO.

4792.1G - Disallowance Letter to Appropriate Recipients

(Rev. 1, 05-21-04)

After headquarters clearance has been obtained, the RO transmits the letter to the State by certified mail, return receipt requested and sends a copy of the letter to CO.

NOTE: Once an appeal has been filed, the RO does not communicate with the State concerning the disallowance. All communications must be by or with the consent of the attorney assigned to handle the case.

4793 - Establishing Records Supporting Non-Audit Medicare and/or Medicaid Disallowance Actions - RO Procedures

(Rev. 1, 05-21-04)

The RO maintains a disallowance action record containing information necessary to support the disallowance decision. The RO includes supporting documentation for items addressed in the disallowance notice. See Exhibit 221 for a model non-audit disallowance notice.

4793A - Disallowance Analysis Memorandum (DAM)

(Rev. 1, 05-21-04)

The appropriate RO/ARA must prepare a DAM for each disallowance taken. The DAM is to be a summary of pertinent facts presented in greater detail than in the disallowance letter, so that a reader who is unfamiliar with the disallowance action is able to fully understand it. Specifically, the DAM should contain:

- A chronology of events to date;
- An explanation of why the disallowance should be taken;
- Detailed findings of fact and an analysis as to why these findings are supported;
- The disallowed amount, identified by quarter, either by proration or by specific item of cost;
- A statement and discussion of the State's position, if known, accompanied by the regional rebuttal or conclusion concerning the validity of the argument;
- If the disallowance was based on a statistically valid sample, a detailed explanation of the sampling plan to include the methodology and computations used to arrive at the disallowed amount;
- A statement as to whether a court order is in effect or litigation is in process;
- Copies of related correspondence; and
- Copies of hours, regulations, and CMS instructions.

4793B - Claim-Related Work Papers

(Rev. 1, 05-21-04)

The RO keeps as backup material copies of all summary work papers, along with copies of journal entries, ledgers, or other documents showing that the State has made a claim. These are documents that support amounts claimed on Form CMS-2824 expenditure source documents. If the amount claimed is part of a larger figure, the RO includes in the DAM an explanation with cost accumulation methodology and computation. Where appropriate, the RO includes copies of audits, contracts, pertinent parts of cost allocation plans, applicable sections of the State plan, and State cost distribution methodologies.

4793C - Citations of Authority

(Rev. 1, 05-21-04)

The RO keeps copies of the cited regulation, interpretations, policy, law, or whatever authority is used to substantiate the disallowance, a copy of the regional attorney's opinion, if any, and a copy of any material associated with litigation.

The RO provides a copy of the DAM and the proposed disallowance letter to the office of the regional counsel handling the case.

4794 - Collections - RO Procedures

(Rev. 1, 05-21-04)

4794A - Processing Collections

(Rev. 1, 05-21-04)

Audit disallowance notices include a request for full repayment within 30 days. If checks in full or partial payment of audit disallowances made out to CMS are received by the RO, the RO accepts them and forwards them to CO for processing. The RO reviews §4796 and takes appropriate updating action each time a check is received. The RO enforces interest charges if a Medicare debt is not repaid within thirty days of the repayment notice. (See subsection C.)

4794B - Appeal Will Suspend Collection Action

(Rev. 1, 05-21-04)

If the State appeals CMS' determination, collection actions will be suspended pending a final decision on the appeal, unless otherwise requested by the State. However, if the disallowance is sustained (fully or partially), interest will be charged for the full period, as described in subsection C.

4794C - Calculating Interest Charges

(Rev. 1, 05-21-04)

The RO is responsible for assessing the interest charged on the total amount of a disallowance that is unpaid as of the "due date." If the resources cited below cannot be obtained from the ARA for Financial Operations, the RO phones the CO Division of Accounting for assistance in calculating the interest due.

4794C1 - Interest on Medicare Disallowance

(Rev. 1, 05-21-04)

Interest on a Medicare disallowance accrues from the date on which the notice is sent to the SA. (Waive interest if the debt is paid in full within 30 days after the date of notice.) If the State fails to appeal a disallowance within 30 days, the RO contacts CO immediately to offset the overpayment by reducing the current award.

4794C2 - Interest on Medicaid Disallowance

(Rev. 1, 05-21-04)

Interest on a Medicaid disallowance begins to accrue on the date of disallowance, and ends on the date of final decision, if the State elects to retain the disputed funds during the appeal, and if the disallowance is upheld by the Grant Appeals Board. If the State is silent on its election to retain funds during the appeal, the RO notifies CO immediately to arrange for offset pending the appeal decision. If the State does not formally appeal the disallowance within the specified 30-day time period, no interest is assessed. Immediately notify CMSO to arrange for offset of the disallowance by issuing a negative grant award. The failure of a State to submit a revised expenditure report does not preclude offsetting against quarterly awards.

4794C3 - Interest Rates

(Rev. 1, 05-21-04)

Interest rates on delinquent Medicare disallowances are set by the U.S. Treasury rates published in their quarterly Treasury Fiscal Requirements Manual Bulletins. The rate is based on the current value of funds to the Treasury. Interest rates on delinquent Medicaid disallowances are based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates during the period in which interest is to be charged. Interest charges on extended Medicare repayment plans are based on the Treasury's monthly Schedule of Certified Interest Rates With Range of Maturities. Extended repayment plans may not contain a grace period for late payments.

4794C4 - Date of Payment

(Rev. 1, 05-21-04)

The "date of payment" is the date of offset against quarterly Medicaid grant awards or the date of reduction of Medicare annual awards.

4794D - Periodic Notices of Amounts Still Due

(Rev. 1, 05-21-04)

The RO keeps up-to-date records of balances due on all determined overpayments, reflecting reductions when made by payment or by CMS offset action taken as a result of the SA's downward adjustment of quarterly expenditure reports to offset the debt. If the quarterly expenditure report includes a specific downward adjustment to offset the debt, the RO considers the reduction to have been made at the end of the calendar quarter to which the expenditure report pertains, in order to calculate interest on the balance still due. If the State has failed to take the required offset from the quarterly expenditure

report, the RO reduces such expenditures (including calculation and reduction for interest), and forwards documentation to DA through CO for offset through the awards process. The RO notifies the SA, just before the end of each quarter in which a balance remains, of the amount still due including current interest. This notice will serve as a reminder of offset action to be taken on expenditure reports by the State.

4794.1 - Accounts Payable - RO Procedures

(Rev. 1, 05-21-04)

If it is determined as the result of an audit that funds are owed to an SA by CMS and that payment of such amounts will not exceed the approved budget for title XVIII funding, CO will ensure that the necessary funds are made available to the SA after receipt of revised State-submitted, ARA-approved expenditure reports for the audited period. In those cases where the SA chooses not to request payment, the RO notifies CO that will in turn notify DA to eliminate the account payable from the record. Similarly, if the SA does not forward revised expenditure reports after notice by the RO to do so, and the RO determines that the SA is not going to forward them, it notifies CO which will notify DA to eliminate the account payable from the record.

4795 - Audit Clearance Document - RO Procedures

(Rev. 1, 05-21-04)

Upon issuance of the final report, the audit is placed on the audit agency's list of pending audits and remains pending until that agency receives (and accepts) an audit clearance document (ACD) (Exhibit 222) showing the resolution of all recommendations. An audit clearance document provides a uniform medium by which full information is furnished to involved parties stating CMS' decision as to actions to be taken and monies to be recovered as a result of the audit report. Therefore, following agreement with the SA on implementation, the RO completes an ACD listing each recommendation, the final determination made, the action to be taken, and the agreed upon time schedule. If the final determination differs from OIGAA's position, the RO includes the rationale for the deviation.

4795.1 - RO Preparation and Processing Audit Clearance Document

(Rev. 1, 05-21-04)

4795.1A - Part I - Decisions by CMS

(Rev. 1, 05-21-04)

This part shows decisions by CMS. The RO completes as follows:

1. **Date** - Date submitted by RO.

2. **Audit Control No.** - Number assigned to audit report by OIGAA.

3. **Report Date** - Date audit report was issued.

4. **Cognizant PoC** - CMS in all cases.

5. **Program** - Program covered by audit report. In those instances where more than one program is covered, the RO indicates program with largest amount of funds (Medicare, Medicaid, Survey and Certification, or QIO.)

6. **Other Principal Operating Components** - All PoCs other than CMS involved in the audit report.

7. **Grantee/Contractor** - Name and address of the SA.

8. **Grant/Contract No** - Leave blank.

9. **Common Accounting No** - For monetary findings, the RO uses the common accounting number (CAN) for the organizational entity that made the original obligation. This information will be included in the audit reports. If not in the report, the RO obtains this information from the regional OIG/OAS.

10. **Appropriation No** - For monetary findings, the RO uses the appropriation number for the program from which the original obligation was made. This information will be included in the audit report. If not in the report, the RO obtains it from the regional OIGAA.

11. **Audit Recommendation** - The RO states the recommendation (not the finding) as it appears in the audit report. The RO shows each recommendation on a separate page. The RO uses the continuation sheet for this purpose. Amounts Recommended for Financial Adjustment

12. **Finding Code - Cost Element** - The RO shows code number and type of expense disallowed. (These are obtained from the audit report.) No more than one finding code is permitted on each line.

13. **Amount Recommended** - The amount to be shown in this column is the amount recommended for adjustment that is being addressed by the ACD. If, for some reason, only a portion of one recommended amount is being addressed, the RO shows this lesser figure in this column.

14. **Amount Sustained by PoC** - The RO shows the amount of this recommendation that is being upheld by CMS. It is the amount in this column that will determine the amount entered into CMS' accounting records for recovery from the auditee. If less than 85 percent of a recommendation of $100,000 or more is upheld, the RO obtains the concurrence of the CMS Administrator or Deputy Administrator and attaches it to the ACD.

15. **Action Taken on Recommendation** - The RO indicates briefly the actions CMS is requiring the auditee to take to implement the recommendation. If several steps need to be taken, the RO includes target dates for their accomplishment. When CMS does not concur with a recommendation, the RO includes a concise explanation of the basis for nonconcurrence. If the report was processed under prerelease procedures and CMS is deviating, or allowing an auditee to deviate, from a previously agreed upon position, the RO furnishes a concise explanation for the deviation. The RO also includes an explanation of the extent of consultation with OIG/OAS on the matter, prior to advising the auditee that the audit has been resolved. In order to more adequately describe the circumstances resulting in nonconcurrence, the RO attaches supporting documentation to the ACD. When the action taken on a recommendation cannot be fully explained within the space provided, the RO continues the explanation on bond paper. Pertinent correspondence must be attached that will aid in explaining CMS' action on this recommendation.

16. **Signature** - The signature of the RA must appear on the right hand side as "Reviewer" if the ACD consummated a settlement or decision. All ACDs should be signed by the RO originating analyst or responsible audit officer.

17. **Office of the General Counsel (OGC) Approval** - If CMS differs in it's interpretation of the law, rule, or regulation used by OIG/OAS to support its recommended disallowance and does not uphold this disallowance (management or financial), OGC's concurrence with CMS' position will be evidenced on the ACD by Counsel's signature or the attachment of the OGC opinion. CO will attach the OGC opinion.

18. **Part I - Continuation Sheet** - The RO uses this page when more than one recommendation is being addressed.

4795.1B - Part II - Recommendations Remaining Open

(Rev. 1, 05-21-04)

The RO includes this page with all ACD submissions and lists on this page any recommendations (or portions thereof) not covered by part I of the ACD; e.g., a financial recommendation that is awaiting a formal disallowance procedure before it can be cleared.

On this page the RO indicates the current date, audit control number, finding code, and recommendation(s) and amount (if any) remaining open. If the ACD clears all recommendations in the audit report, the RO shows the word "none" on this page.

4795.1C - Attachments

(Rev. 1, 05-21-04)

When applicable, the RO furnishes the following additional documentation with the ACD. (All documents listed below must bear proper signatures and approvals.)

- Disallowance letter, if one was necessary (5 copies);
- Paperwork to verify the recovery of disallowed funds (2 copies);
- Statement of concurrence of CMS Administrator if less than 85 percent of a recommendation of $100,000 or more was upheld (2 copies); and
- Agreement letter to SA director and his/her concurrence, as required in §§4789 or 4791 (2 copies).

4795.1D - Amended ACDs

(Rev. 1, 05-21-04)

In some cases, a situation may arise which would change CMS' position as stated on the ACD when an audit was cleared, such as when an appeal overturns CMS' decision or an additional amount of money is recovered as a result of the audit. In these situations, the RO prepares an "amended ACD" stating the nature of the change and how it effects the original ACD and adds the word "AMENDED" to the upper right-hand corner of each page.

4795.1E - Dispatching ACD

(Rev. 1, 05-21-04)

The RO sends the original and four copies of the ACD to CO. If Medicaid is responsible for the funds overpaid in the audit, the RO Division of Financial Operations will prepare the ACDs for the audit and will forward them to ALS. Some audits are combined with Medicaid program audits in such a way that ACDs must be coordinated by the Office of the Regional Administrator before release.

4795.1F - CO Action

(Rev. 1, 05-21-04)

CO reviews each audit report and ACD to:

- Verify that the ACD addresses all of the management recommendations;
- Verify that all recommended financial adjustments are addressed on the ACD and that the amounts are accurate; and
- Submit the required number of copies of the ACDs to Audit Liaison Staff in an acceptable and timely manner.

If CO has questions about the ACD, it will request additional information from the RO. Upon completion of its review, CO transmits the original and three copies to ALS. That office transmits the ACD to OIG/OAS.

4795.2 - Clearing Audit Clearance Document - RO Procedures

(Rev. 1, 05-21-04)

An audit may be cleared when:

- The RA has rendered a decision as to what action CMS will require of the State to resolve each management recommendation in the report, and that decision has been transmitted to the State; and
- A decision has been reached as to the amount of the financial recommendation to be upheld by CMS and to be repaid by the State, and that decision has been transmitted to the State.
- It is not necessary that corrective action be completed before an ACD can be processed. Even though a determination may be appealed, the ACD should be

prepared by this point. The RO should make every effort to include the entire audit in a single ACD issuance in order to expedite the clearance process.

On occasion, clearance of an item occurs when the RO rejects an OIGOA recommendation in whole or in part. Where the basis for disagreement is a difference in interpretation of the law, rule, or regulation used by the OIG/OAS to support its recommended action, the ACD must be cleared through the Office of the General Counsel before being sent to the Audit Agency. (CMSO will request General Counsel reaction.) The RO transmits the ACD to CO and, in a covering memorandum, points out that a disagreement of this nature exists and gives the rationale for the RO position.

4795.3 - Closure Versus Clearance - RO Procedures

(Rev. 1, 05-21-04)

A finding is cleared when there is conclusive agreement on a PoC or, in a financial audit, on the amount overpaid. RO completion of an ACD showing that a final determination has been made on each OIG/OAS recommendation will clear an audit from the OIG/OAS's pending list of audits or Stewardship Report and from CMS' status report.

A finding is closed when the RO reports it has been satisfied, by evidence or observation, that correction has been achieved, or when the overpayment has been offset or repaid. An audit is not considered closed until the SA has implemented all the final decisions and the implementation verified. The RO furnishes documents verifying recovery of funds by check or by offset to the Audit Liaison Staff.

4796 - Audit Findings and Recommendations Remaining Open at End of Four Months - RO Procedures

(Rev. 1, 05-21-04)

If the SA and the RO fail to reach agreement on all audit recommendations (as contained in the final report) and their implementation by the end of 4 months following the date of the final report, the RO completes the ACD within 10 working days. The RO shows those recommendations that have been cleared up to that time in the space provided together with implementation plans and expected implementation schedule. The RO lists those not cleared in the page headed "Findings Remaining Open," together with the reason not yet cleared and the expected date of resolution. The RO prepares an ACD even when it is certain that a disallowance will be appealed.

It is the responsibility of the RO to follow up on cleared audit reports until it has been determined that the State has taken action necessary to fully implement all audit recommendations. When this has been done, the audit will be closed. In order that central office components and ALS may be kept abreast of actions taken by the auditee and regional personnel to close audit recommendations, the RO submits a status report

quarterly on all cleared audits not previously closed. The RO sends one copy to ALS and one copy to CO 15 days after the end of the quarter.

When audits have been cleared from the OIG/OAS Stewardship Report but are not entirely closed, ALS, not OIG/OAS, will maintain follow-up control. The RO sends a memo to CO to report how and when final closure has been verified. CO will then advise ALS to discontinue the control.

Disposition of Medicare and Medicaid Records

4800 - Retention and Destruction of Medicare and Medicaid Records

(Rev. 1, 05-21-04)

The SA's copies of records produced in the administration of the State survey program become Federal records when the original documents are transmitted to CMS. The provisions of the Federal Records Disposition Act, therefore, govern retention and destruction of these records.

The following sections list the various types of title XVIII and XIX records to be retained in the SA and the applicable periods of retention. However, where State law or practices require longer retention periods than those shown, State law or practice is controlling.

4801 - Provider Certification Records

(Rev. 1, 05-21-04)

(See http://cmsnet.cms.hhs.gov/hpages/iocs/records/admin4.htm)

PROVIDER RECORDS

4801A. Provider Certification Files (N1-440-95-1, Item 9)

(Rev. 1, 05-21-04)

Documents relating to the survey and certification of suppliers and providers of service. Included are official certification and transmittal forms, survey report forms, utilization review plans, provider agreements, transfer agreements, plans of correction, civil rights compliance forms, intermediary designation and tie-in notices, certification letters, and various forms and correspondence used in the certification process with respect to individual facilities. Excluded from this definition are surveyor's notes, rough copy survey report forms, and other work papers which are merged into and superseded by a final product.

DISPOSITION:

1. CMS Regional Office

   a. Non-participating Facilities

   Cutoff file after termination or denial. Destroy 6 years after cutoff.

b. Participating Facilities

(1) Maintain the Form CMS-1561--(Health Insurance Benefits Agreement) the two most recent certifications and background/support materials - Maintain in an active file for as long as the facility is participating.

(2) Survey report forms and related documents - Cutoff file after completion of survey. Destroy 6 years after cutoff.

(3) Survey report forms and related documents pertaining to access hospitals, nursing homes and home health agencies-Cutoff file after removal from the access category and completion of the survey. Destroy 4 years after cutoff.

(4) Mammography Facilities Files - Cutoff file upon approval of schedule and transfer to the FRC. Destroy 3 years after cutoff.

2. State Agencies

a. Non-Participating Facilities- Cutoff file after termination, closure, withdrawal, or denial. Destroy 4 years after cutoff.

(1) Non-Certified Facilities - Cutoff file after termination, closure, withdrawal, or denial. Destroy 1 year after cutoff.

b. Participating Facilities

(1) Retain a facility's (hospitals and skilled nursing facilities (SNFs)) current utilization review plan, transfer agreements and floor plan or physical plant layout. Destroy when superseded, obsolete or when facility becomes non-participating.

(2) Maintain the two most recent certification actions at all times. Destroy all other records when 4 years old.

4802 - Budget and Financial Report Files- Records to Be Retained

(Rev. 1, 05-21-04)

These files are used to estimate, justify, and approve SA program costs, and to account for funds received and expended by the SAs.

The files include: Form CMS-1465A, "State Agency Budget List of Positions"; Form CMS-1466, "State Agency Schedule for Equipment Purchases"; Form CMS-435, "Quarterly Expenditure Report(s)"; Form CMS-434, "Certification Workload Report(s)"; and indirect cost forms.

4802A. Provider Statistical and Reimbursement Reports (BHI.g:40-2, Item BB)

EDP printouts or microfilms showing summaries of payments to hospitals, skilled nursing facilities, home health agencies, and other providers of service. They are used to effect cost settlements between the intermediaries and the providers for program validation purposes, and to determine accuracy of cost reports. These reports contain Part A and Part B inpatient and outpatient information, inpatient statistics, total bills, covered costs, and other related data.

DISPOSITION:

1. CMS Headquarters - Destroy printouts after a total retention of 3 years after the date issued. Destroy microfilm upon receipt and verification of subsequent film.

2. Intermediaries - Destroy after a total retention of 5 years after completion of audit and/or settlement process for provider cost report for corresponding fiscal year.

4802B. Medical Facilities Directory Files (BHI.g:40-2, Item CC)

Listing of providers of service showing provider identification and intermediary numbers, effective date, and city where located. Also included are alphabetical listing of facilities by State, cities within the State, and facility name within the city. These lists contain mailing addresses, provider numbers, intermediary numbers, effective dates, termination codes, billing elections, radiological and laboratory services, total beds, nursing beds, and accreditation by Joint Commission on Accreditation of Hospitals and the American Osteopathic Association.

DISPOSITION: Destroy when superseded or obsolete.

4802C. State Agency Budget and Financial Report Files (NC1-440-79-1, Item 50, description revised 11/2000)

Files used to estimate, justify, and approve State agency health insurance program costs, and to account for funds received and expended by the State agencies. Included are Forms CMS-435 (used by the State agencies to request funding by CMS regional offices to approve budgets, by the State agencies to request supplemental funding, and by the State agencies to report quarterly expenditures)--State Survey Agency Budget/Expenditure Report; CMS-1465A--State Agency Budget List of Positions; CMS-1466--State Agency Schedule for Equipment Purchases; and indirect cost forms. (Form CMS-435 replaces Forms CMS-1465, CMS-1467, CMS-1468 and CMS-1469A.)

DISPOSITION:

1. CMS Headquarters and Regional Offices - Destroy after a total retention of 6 years following the close of the budget year.

2. State Agencies - Destroy after a total retention of 3 years after HHS audit or after a total retention of 5 years after the close of the budget year, whichever is earlier.

4802D. State Agency Agreements (BHI.g:40-2, Item EE)

Agreements entered into with the State agencies by the Secretary of Health and Human Services under the provisions of Section 1864 of the Social Security Act, by which the State agency assists CMS in determining whether health care providers and suppliers met and continue to meet the requirements for coverage or participation. Also included are “sub-agreements” by which State agencies subcontract some Medicare functions to other governmental or private organizations.

DISPOSITION:

1. CMS Headquarters - PERMANENT. Transfer to the FRC at the close of the calendar year in which terminated. Transfer to the National Archives 20 years thereafter.

2. Regional Offices - Destroy after a total retention of 5 years after the close of the calendar year in which terminated.

3. State Agencies - Dispose of according to State practice.

4802E. State Agency Review Files (BHI.g:40-2, Item FF)

Documents relating to administrative review of State agency operations and certification procedures. Included are reports of visits, communications concerning improvements in operations, and other papers pertaining to reviews of State agency practices.

DISPOSITION:

1. CMS Headquarters - Destroy after a total retention of 5 years after the close of the calendar year in which dated.

2. State Agencies - Dispose of according to State practice.

4802F. State Buy-In Agreements (BHI.g:40-2, Item GG)

Agreements entered into with the State agencies by the Secretary of Health and Human Services under the provisions of section 1843 of the Social Security Act. The agreements provide coverage under the Supplementary Medical Insurance Program for certain individuals receiving money payments under State approved public assistance plans. Buy-In Agreements allow coverage for individuals not normally eligible for coverage.

DISPOSITION:

1. CMS Headquarters - PERMANENT. Transfer to the FRC at the close of the calendar year in which terminated. Transfer to the National Archives 20 years thereafter.

2. Regional Offices - Destroy after a total retention of 5 years after the close of the calendar year in which terminated.

3. State Agencies - Dispose of according to State practice.

4802G. Program Validation Reviews (BHI.g:40-2, Item HH)

Documents relating to program validation reviews conducted to identify the degree to which program provisions are being properly applied by the providers of health care services. Included are planned validation reviews, notice of visits, and other papers directly related to the program validation review process.

DISPOSITION: Place in inactive file after 2 years or upon receipt of subsequent review, whichever is earlier. Destroy after a total retention of 5 years.

4802H. Detailed Printouts (Depots) (BHI.g:40-2, Item II)

EDP printouts showing individual bill and payment information for hospitals skilled nursing facilities, home health agencies, and other providers of service. These reports are used by intermediaries and providers to reconcile the Provider Statistical and Reimbursement Reports to their own records by itemizing which bills have been processed by CMS and are included in the PS&R report.

DISPOSITION:

1. CMS Headquarters - Destroy printouts after a total retention of 3 years after the date issued.

2. Intermediaries - Destroy after a total retention of 5 years after the completion of the audit and/or settlement process for provider cost report for the corresponding fiscal year.

4802I. Interim Rate Listings (BHI.g:40-2, Item JJ)

Listings of interim rates in use by intermediaries in making interim payments to hospitals, skilled nursing facilities, home health agencies, and other providers of services. These listing are used as a source of information and for studies.

DISPOSITION: Destroy after a total retention of 5 years.

4802J. Provider Hearing Files (BHI.g:40-2, Item MM)

These files accumulate when a provider of services is dissatisfied with CMS' determination that it does not meet the conditions for participation in the Medicare program and requests an administrative hearing on the matter. The documents are used by CMS to support its initial determination at the hearing. Included are copies of provider inspection reports, correspondence, and similar records relating to provider operations. After the hearing, the files must be retained in the event that the provider seeks court review.

DISPOSITION: Transfer to the CMS Records Holding Area at the close of the calendar year in which hearing is held. Hold for 2 years and then transfer to the FRC. Destroy after a total retention of 7 years.

4802K. Supplementary Medical Insurance (SMI) General Enrollment Period (GEP) Records (N1-440-95-1, Item 10)

Records consisting of source documents, (the CMS-L40D) for all individuals who responded in the direct mail solicitation for SMI enrollment. The records contain such information as beneficiary name, claim number, address, premium amount, and a check mark reflecting individual's election or refusal of enrollment.

DISPOSITION:

1. Source Document - Cutoff at the close of the General Enrollment Period. Destroy 1 year after cutoff.

2. Timely Filed Yes Reply List - Cutoff at the end of the calendar year. Destroy 3 years after cutoff.

4802L. Claims Processing File (Previously, Quality Assurance File--NC1-440-76-29, Item II)

The Medicare Part B Carrier Quality Assurance System was designed as a program for measuring the quality of carrier claims processing operations and to provide management tools for identifying and monitoring actions needed to derive improvements in claims processing. Claims processing files are transmitted electronically to CMS' Data Center (HDC) by all Part B carriers.

DISPOSITION: Retained at the HDC for a total retention of 3 years.

4802M. Correction Payment Action Summary Report (NC1-440-76-29, Item III)

Documents relating to corrective payment action taken on Part B claims selected for end-of-line or quality assurance sample review. Included are summary report forms and transmittal letters.

DISPOSITION: Destroy after a total retention of 1 year.

4802N. **Civil Litigation Case Files** (NC1-440-79-1, Item 3HH)

Case files documenting central office involvement in Medicare civil litigation. Civil Litigation cases usually have no fraud involvement. They relate to any aspect of the Medicare program, such as overpayment or underpayment of monies by CMS to contractors or providers of services, coverage and entitlement questions, provider terminations, and regulation promulgation and enforcement. Unless settled beforehand, civil litigation cases are heard in Federal (and rarely State) courts. Documentation in the case files may include but not be limited to, complaints and answers, court orders, transcripts, briefs, evidentiary material (cost reports, accounting data, affidavits, etc.), correspondence and related background information. The Department of Justice maintains the record copy of cases reaching the court level. The Civil Litigation and Hearings Branch maintains record copies of central office involvement in these cases.

DISPOSITION: Place in an inactive file after final action on the case. Cut off inactive file at the close of the calendar year in which final action was taken, hold 2 additional years, and then transfer to the FRC. Destroy when inactive for a total retention of 5 years.

4802O. **Professional Qualifications File** (NC1-440-79-1, Item IV.A.)

Records of certain individuals who are employed in hospitals and clinical laboratories, or who are self-employed providing therapy and medical services who have taken HHS proficiency examinations. The records contain professional qualification information on the academic and experience qualifications of the individuals and identify information such as social security number, name, address license number and eligibility, and results of HHS proficiency examination. Records are maintained by State agencies and regional Medicare offices, and are used to determine whether individuals rendering health care services meet qualification requirements.

DISPOSITION: Transfer to an inactive file upon termination of individual's participation. Destroy after a total retention of 5 years.

4802P. Teaching Hospital Medical Records Audit Files (NC1-440-78-1, Item A)

Documents created from audits of teaching facilities' medical records, conducted nationwide by carriers. These audits, conducted annually or semi-annually, are intended to verify, through medical records, the degree of participation of supervising physicians in the care and treatment of beneficiaries for which payment is requested under Part B Medicare. Documents in these files include copies of Part B claims records, letters of inquiry and responses from facilities or physicians, copies of documentation supplied to carriers, and related correspondence.

DISPOSITION: Transfer to the FRC after completion of the audit. Destroy after a total retention of 4 years after completion of audit.

4802Q. Teaching Hospital Medical Record Recoupment Audit Files (NC1-440-78-1, Item B)

Documents relating to periodic audits of teaching facilities nationwide by carriers to recover overpayment. These audits are similar to the teaching hospital medical record audits. Findings adverse to the facility may be appealed through the fair hearing process. Documents in the files include copies of Part B claims records; correspondence or documentation supplied by the facility or physician; and documents relating to the fair hearing (transcripts, decisions, etc.).

DISPOSITION: Transfer to the FRC after completion and settlement of the audit. Destroy 4 years after completion of audit.

4802R. Utilization Review Files (NC1-440-80-1)

Records documenting postpayment utilization review of physicians, conducted by State and local medical societies. These files are maintained by carriers nationwide and contain copies of Part B claim forms, medical documentation, determination documentation, correspondence and related background documents. No original claims records are included in these files. Physician overpayment may be collected based on the results of the reviews.

DISPOSITION: Transfer to an inactive file upon completion of review. Close out inactive file at the end of each calendar year, and transfer to Federal Records Center (FRC). Destroy after a total retention of 7 years.

4802S. Provider/Supplier and Durable Medical Equipment Supplier Application (N1-440-01-1)

Document relating to the enrollment of providers and suppliers into the Medicare program. These include but are not limited to Form CMS-855 enrollment forms (OMB Approval No. 0938-0685) and all supporting documents. Also included are attachments that would be submitted with the application. These include but are not limited to copy(s) of: Federal, State and/or local (city/county) professional licenses, certifications and/or registrations; Federal, State, and/or local (city/county) business licenses, certification and/or registrations; professional school degrees or certificates or evidence of qualifying course work; curriculum vitae/resumes; CLIA certificates and FDA mammography certificates; controlled substances registrations from the Drug Enforcement Agency; Central Office letter issuing an indirect billing number to a managed care organization or plan.

1. Provider/Supplier and Durable Medical Equipment Supplier Application

   a. Unprocessed applications as a result of provider/supplier failing to provide additional information

      DISPOSITION: Destroy when 7 years old.

   b. Approved applications of provider/supplier

      DISPOSITION: Destroy 15 years after the provider/supplier's enrollment has ended.

   c. Denied applications of provider/supplier.

      DISPOSITION: Destroy 15 years after the date of denial.

d. Approved application of provider/supplier, but subsequently, the billing number has been revoked

DISPOSITION: Destroy 15 years after the billing number is revoked.

e. Voluntary deactivation of billing number

DISPOSITION: Destroy 15 years after deactivation.

f. Provider/Supplier dies

DISPOSITION: Destroy 7 years after date of death.

2. Electronic Mail and Word Processing System Copies

a. Copies that have no further administrative value after the recordkeeping copy is made. Includes copies maintained by individuals in personal files, personal electronic mail directories, or other personal directories on hard disk or network drives, and copies on shared network drives that are used only to produce the recordkeeping copy.

DISPOSITION: DELETE within 180 days after the recordkeeping copy has been produced.

b. Copies used for dissemination, revision or updating that are maintained in addition to the recordkeeping copy

DISPOSITION: DELETE when dissemination, revision, or updating is complete.

4803 - Title XVIII State Agreements

(Rev. 1, 05-21-04)

The SA retains §1864 agreements (see §4002) and interagency subagreements (see §4006) during the life of the agreements, after which they may be disposed of according to State practice.

4804 - Title XIX State Plans

(Rev. 1, 05-21-04)

The SA retains State plans, required by §1903 of the Act, during the life of the plan, after which they may be disposed of according to State practice.

4805 - SA Review Files

(Rev. 1, 05-21-04)

Documents relating to administrative review of SA operations and certification procedures, such as reports of visits, communications concerning improvements in operations, and other papers pertaining to reviews of SA practices, are to be destroyed 3 years after the year in which the document was prepared or when no longer needed for reference, whichever is later.

4806 - Destruction of Records

(Rev. 1, 05-21-04)

When records no longer need to be retained, the SA may destroy them. To ensure confidentiality, the SA destroys records by shredding, mutilation, or other protective measures.