DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Clinical Standards and Quality/Survey & Certification Group

Admin Info: 17-17-ALL

DATE: **June 16, 2017**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **FINAL** Fiscal Year (FY) 2017 State Medicare Allocations for Survey & Certification

Memorandum Summary

- **State Allocations:** Attachment 1 contains FY2017 Medicare allocation figures for each State, with details for increases allocated pursuant to the State by State review, and additional columns to track supplementary allocations for targeted surveys, validation surveys, and other factors.
- **Review Process for Amounts:** The Centers for Medicare & Medicaid Services (CMS) Regional Offices reviewed each State's budget individually, examining workloads, spending patterns, performance, and particular budgetary needs.
- **Hospice Funds:** Congress appropriated additional funds dedicated to increasing the frequency of recertification surveys for hospices. These funds must be tracked and accounted for separately.
- **Non-Delivery Deductions:** A few States have non-delivery deductions, and a few States have a portion of their budgets identified as benchmarked and subject to an improvement plan due to performance issues.

A. Overview - Medicare Survey & Certification Budgets

Congress appropriated funds in FY2017 at the same level of the FY2016 Medicare Survey & Certification (S&C) budget. Via the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, Congress also appropriated additional targeted funds to enable the frequency of hospice recertification (and related hospice surveys) to increase from a once-every-six-year frequency to an average of once every three years. Although there was no increase in the Medicare S&C appropriation level, we made every effort to allow an average of 0.5% increase to States. Based on State requests, spending history, and performance, some States are receiving an allocation above the 0.5% level, while others are receiving amounts below the 0.5% level, pursuant to analysis and discussions with the Regional Offices (ROs).

Attachment 1 contains the final FY2017 Medicare allocation figures for each State. The attachment also details any increase or (decrease) allocated after the CMS State-by-State review, and additional columns to track supplementary allocations for targeted surveys, validation surveys, and other factors.

Increases in Medicare S&C base allocations for States range from 0% to 5.2%. The only States that received fewer funds in the base allocation (as distinct from temporary non-delivery deductions) are States that either requested fewer funds or those States that were determined in the RO and Central Office (CO) discussions to be awarded less for multiple reasons.

In addition, supplementary funds are provided for a variety of targeted surveys, including:

- MDS/Staffing Targeted Surveys;
- Validation Surveys

Hospice survey funds, including the Hospice Validation Surveys, are provided in a separate category, as they must be tracked separately. Please refer to AdminInfo 16-11-Hospice (December 11, 2015) for reminders on the method for reporting all hospice survey expenses.

Additional details regarding each of the funding categories, and instructions regarding any special cost accounting that may be involved, are provided below in the column-by-column descriptions. **Look to Column D1 for the final FY2016 allocation of Non-Hospice funds and column D2 for Hospice funding.**

We appreciate that there are many moving parts and special considerations involved in the allocations. If a State sees any significant issues with its allocation, or has questions about the allocations or cost accounting, please communicate those promptly to your CMS Regional Office.

B. Explanation of Attachment 1 - FY2016 State S&C Allocation Worksheet

Column A –FY2016 Budget: Column A represents each States FY2016 adjusted budget as previously shown in Appendix 2, column A, of AdminInfo16-29.02-ALL: FY2017 Draft MPD.

Column B.1. – Increased/Decreased Funds: Column B.1. shows the increase/decrease in each State's base allocation for FY2017 compared with the adjusted allocation for FY2016.

Column B.1a – Percentage Increase/Decrease: Column B.1a. shows the percentage increase/decrease in each State's base allocation for FY2017 compared with the adjusted allocation for FY2016, not including the IMPACT funds for hospice surveys or any supplementary funding.

Column B.2 – Hospice IMPACT Funds: The IMPACT Act of 2014 provided additional S&C funding to perform workload on non-deemed Hospice facilities. The purpose of this funding is to bring non-deemed Hospice survey frequencies to once every three (3) years. These sums represent the funds requested by each State.

Costs for all hospice surveys must first be assigned to the IMPACT funds. This includes recertification visits, revisits, complaint investigations, and validations surveys of deemed hospices. See instructions communicated in Admin Info16-11- HOSPICE, issued on December 11, 2015 regarding how all hospice funds are to be reported.

If, as the year progresses, the allocation to the State that is reflected in Column B.2 appears to be insufficient to cover all costs for all hospice survey work in FY2017, please contact your CMS RO. We will seek to respond quickly as to whether we might be able to arrange for an increase to those funds; if not, the expenses above the special IMPACT Act allocation, will roll up to the State's Medicare allocation, as explained in AdminInfo 16-11-Hospice.

Column B.2a – Overall Percentage Increase/Decrease: Column B.2a reflects the percentage increase/decrease represented by the combination of increased/decreased Medicare S&C funds, plus IMPACT hospice funds, compared with the FY2016 adjusted base allocations.

Column B.3 – Subtotal Medicare S&C Funds: Column B.3 is the total of Medicare S&C funds, not including hospice funds or supplementary funds.

Column C.1 – One-time Adjustments: Column C.1 includes funding one-time adjustments as a result of the RO/CO budget discussions.

Column C2. Non-Delivery Deductions: This column details the non-delivery deductions in FY2017 in response to FY2016 performance lapses.

Column C.3 – Supplemental Validation Funding: The expected number of validation surveys for each State can be found in Appendix 3 of AdminInfo16-29-ALL: FY2017 MPD. We will continue to provide supplemental awards for those validation surveys that are completed and for which the Mission and Priority Document (MPD) indicates supplemental awards are to be made.
Note that the amounts listed in Column C.3 of Attachment 1 are the projected supplemental funds to be awarded upon completion of the validation work outlined in the FY2017 MPD.

Our practice in recent years has been to reimburse a State that completes a validation survey and all its required reporting at a national flat rate, using regular Medicare S&C funds. In a case in which the national rate provided more than the cost of the survey, the State was free to blend the overage into its S&C budget to cover other work. If the national rate did not cover the survey's cost, the State was to use regular S&C budget dollars to make up the difference. Medicare reimbursement for validation surveys of any provider type will continue in this manner in FY 2017, including for HHAs that participate in Medicare only. The flat rate is provided, however, only for completed surveys.

The amount of funds for home health validation surveys that is included in Column C.3 represents the Medicare share of HHA validation expenses. For home health agencies that participate in both Medicare and Medicaid, States must ensure that federal survey costs related to such dually-participating HHAs are properly assigned to both Medicare and

Medicaid. States should report their actual validation survey costs, both Medicare and Medicaid, as part of their regular quarterly expenditure reports, both on the main CMS-435 and on the mini HHA CMS-435 (which is a subset of the main CMS-435). Medicaid reimbursement will be provided via the usual Medicaid process, based on the approved expenditure report.

Medicare funds that are provided via a flat rate for completed validation surveys that exceed the actual cost of such surveys at a dually-participating HHA are available for other S&C work by the State. If the Medicare portion of the flat rate does not cover the Medicare part of the cost of the validation survey, the State must make up the difference from its general S&C budget funds, but may contact CMS to see if additional Medicare funds are available.

Supplementary funds for validation surveys of deemed hospice providers will be assigned to the IMPACT hospice funds category and accounted for by States in the same manner as all other IMPACT hospice funds. **The funds for such hospice validation surveys is NOT included in Column C.3., but are subsumed in Column D.2 (which is why D.2. may be higher than Column B.2).**

Column C.4 – Targeted Survey Supplements: Column C.4 provides for the projected costs of the MDS/Staffing targeted surveys that are assigned to each State.

- The MDS/Staffing Targeted surveys are described in more detail in S&C Administrative Memorandum **15-24-NH** issued on March 27, 2015. These are surveys of record for which standard CMS deficiency identification and enforcement procedures apply.

These focused surveys may not be combined with a standard recertification survey. However, the MDS/staffing targeted surveys may be done immediately before or after a complaint survey while the surveyors are onsite. In these cases, each survey must be completed and documented separately, and surveyors will still need to follow the focused survey process as instructed through the training.

The funding shown in Attachment 2 for MDS surveys (and included in Column C.4 of Attachment 1), represents the Medicare share of costs. Insofar as Medicaid also benefits from these surveys, we expect that the total federal costs for these surveys will be split in the usual 50/50 manner. Unless State law or regulation has comparable requirements to the federal resident assessment and MDS requirements, it is permissible for there not to be a State-only license cost for these stand-alone targeted MDS surveys. States are not required to complete a separate CMS Form 435 for MDS targeted surveys; all costs related to such surveys should be included on the main CMS Form 435 report. **SAs must notify CMS CO via the dedicated mailbox**

MDSStaffingSurvey@cms.hhs.gov of the name(s) of the nursing home surveyed, city, state, CMS certification number (CCN) and survey dates.

Column C.4 in Attachment 1 displays the funds for each State for the cost of the MDS targeted surveys.

C. One-Time Funds

We may have a small amount of one-time funds available, principally from non-delivery deductions and contractual adjustments within CO. Priority for FY2017 is for requests for equipment that will improve the ability of State surveyors to participate effectively in distance learning (e.g., dedicated audio-visual or computer equipment), but requests for other types of expenses may still be considered. States may request such funds through their CMS RO *up to COB August 31, 2017* with a copy to CO to Bary.Slovikosky@cms.hhs.gov.

D. Actions Now that Final Allocations are Determined *(All States)*

States should submit the FY2017 budget forms into the S&C online budget system, including the following, no later than July 21, 2017:

1. CMS-435 Budget Request Form. *Note: This form should capture all projected FY 2017 expenditures (including MDS and HHA with OASIS, but not including IMPACT Act Hospice Costs) spread across the appropriate lines of the CMS-435.*
2. 3 mini CMS-435s for MDS and HHA (subset reports of the main CMS-435) and IMPACT Act – Hospice (separate report), with projected expenditures spread across the appropriate line items;
3. CMS-434 Planned Workload Report;
4. CMS-1465A Budget List of Positions; and
5. CMS-1466 Schedule for Equipment purchases

Additional documents for discussion with RO's:

6. Budget narrative with work plan and line by line justification.
7. A single, all-inclusive Tier Statement indicating what Tier workloads the State will and will not be able to accomplish. If circumstances allow for only partial completion of a particular Tier workload, indicate in the Tier Statement which work will not be completed in the Tier, by provider type and the extent of the survey work that the State expects it will be unable to accomplish. Please recall that there is a triage level of complaint investigations in each Tier, so mention those if they come into play.

   Please make a Tier statement as a clearly identified paragraph toward the top of the budget narrative. It can be as simple as "Tiers 1, 2 and 3 will be done, but not initial surveys in Tier 3 and Tier 4." Or the statement can be more detailed, especially if the State will complete part of a Tier, and needs to specify what won't be done in the Tier.
8. Ensure that budgeting for home health surveys includes the appropriate Medicaid fair share for the cost of those surveys using the simplified 50/50 split as described on Page 71 in the FY17 MPD (AdminInfo memo 16-29).

Contact: For general questions, please contact Bary Slovikosky at Bary.Slovikosky@cms.hhs.gov

Effective Date: Immediately. This information should be communicated to all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
David R. Wright

Attachment(s):
Attachment 1: FY2017 Allocations
Attachment 2: FY2016 Non-Delivery Data

cc: Survey and Certification Regional Office Management